SUPREME COURT
OF THE UNITED STATES

No. 09-1158
Title: Toby Douglas, Director, California Department of Health Care Services, Petitioner
v.
California Pharmacists Association, et al.
Docketed: March 24, 2010
Lower Ct: United States Court of Appeals for the Ninth Circuit
Case Nos.: (09-55532)
Decision Date: March 3, 2010
Rule 12.4

Questions Presented

~~Date~~~	~~~~~~~~Proceedings and Orders~~~~~~~~~~~~~~~~~~~~
Mar 24 2010	Petition for a writ of certiorari filed. (Response due April 23, 2010)
Apr 9 2010	Order extending time to file response to petition to and including May 24, 2010, for all respondents.
May 18 2010	Order further extending time to file response to petition to and including May 27, 2010.
May 24 2010	Brief of respondents Independent Living Center of Southern California, Inc., et al. in opposition filed.
May 27 2010	Brief of respondents Lydia Dominguez, et al in opposition filed.
May 27 2010	Brief of respondents California Pharmacists Association, et al. in opposition filed.
Jun 7 2010	Reply of petitioners David Maxwell-Jolly, Director, California Department of Health Care Services, et al. filed. (Distributed)
Jun 8 2010	DISTRIBUTED for Conference of June 24, 2010.
Dec 15 2010	DISTRIBUTED for Conference of January 7, 2011.
Dec 16 2010	Joint supplemental brief of respondents California Pharmacists Association, et al. filed. (Distributed)
Dec 20 2010	Supplemental brief of petitioners David Maxwell-Jolly, Director, California Department of Health Care Services, et al. filed. (Distributed)
Jan 10 2011	DISTRIBUTED for Conference of January 14, 2011.
Jan 18 2011	Petition GRANTED limited to Question 1 presented by the petitions. The petitions for certiorari in No. 09-958 and No. 10-283 are granted limited to Question 1 presented by the petitions. The cases are consolidated and a total of one hour is allotted for oral argument. VIDED.
Feb 17 2011	The time to file the joint appendix and petitioners' briefs on the merits is extended to and including April 14, 2011. VIDED.
Feb 17 2011	The time to file respondents' briefs on the merits is extended to and including June 24,

2011. VIDED.

Apr 7 2011	The time to file the joint appendix and petitioners' briefs on the merits is further extended to and including May 19, 2011. VIDED.
Apr 7 2011	The time to file respondents' briefs on the merits is further extended to and including July 29, 2011. VIDED.
May 19 2011	Joint appendix filed. VIDED. (Statement of costs filed)
May 19 2011	Brief of petitioner Toby Douglas, Director, California Department of Health Care Services filed. VIDED.
May 25 2011	Brief amici curiae of National Governors Association, et al. filed. VIDED.
May 26 2011	Brief amicus curiae of the United States filed. VIDED.
May 26 2011	Brief amicus curiae of APA Watch filed. VIDED.
May 26 2011	Brief amici curiae of Michigan and 30 Other States filed. VIDED.
Jul 15 2011	CIRCULATED.
Jul 19 2011	SET FOR ARGUMENT ON Monday, October 3, 2011.
Jul 29 2011	Brief of respondents California Pharmacists, et al. filed. VIDED. (Distributed)
Jul 29 2011	Brief of respondents Santa Rosa Memorial Hospital, et al. filed. VIDED. (Distributed)
Jul 29 2011	Brief of respondents Dominguez, et al. filed. VIDED. (Distributed)
Jul 29 2011	Brief of respondents Independent Living Center of Southern California, Inc., et al. filed. VIDED. (Distributed)
Aug 4 2011	Brief amici curiae of National Association of Chain Drug Stores, et al. filed. VIDED. (Distributed)
Aug 5 2011	Brief amicus curiae of Chamber of Commerce of the United States of America filed. VIDED. (Distributed)
Aug 5 2011	Motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument filed. VIDED.
Aug 5 2011	Brief amici curiae of Members of Congress filed. VIDED. (Distributed)
Aug 5 2011	Brief amici curiae of American Medical Association, et al. filed. VIDED. (Distributed)
Aug 5 2011	Brief amici curiae of American Civil Liberties Union, et al. filed. VIDED. (Distributed)
Aug 5 2011	Brief amici curiae of American Health Care Association, et al. filed. VIDED. (Distributed)
Aug 5 2011	Brief amici curiae of Former HHS Officials filed. VIDED. (Distributed)
Sep 1 2011	Reply of petitioners Toby Douglas, Director, California Department of Health Care Services filed. VIDED. (Distributed)
Sep 23 2011	Record received from U.S.C.A. for 9th Circuit. (1 envelope)
Sep 23 2011	Record from U.S.D.C. for Central District of California is electronic.
Sep 27 2011	Motion of the Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument GRANTED. VIDED.
Oct 3 2011	Argued. For petitioner: Karin S. Schwartz, Supervising Deputy Attorney General, San Francisco, Cal.; and Edwin S. Kneedler, Deputy Solicitor General, Department of Justice, Washington, D. C. (for United States, as amicus curiae.) For respondents: Carter G. Phillips, Washington, D. C.)

No. _____

FILED

091158 MAR 24 2010

In the

Supreme Court of the United States

CLERK

DAVID MAXWELL-JOLLY, Director of the Department of Health Care Services, State of California, et al.,

Petitioners,

v.

CALIFORNIA PHARMACISTS ASSOCIATION, et al.,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

Under 42 U.S.C. § 1396a(a)(30)(A) of the Medicaid Act, a state that accepts federal Medicaid funds must adopt a state plan containing methods and procedures to "safeguard against unnecessary utilization of . . . [Medicaid] services and . . . assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available . . . at least to the extent that such care and services are available to the general population." The Ninth Circuit, along with virtually all of the circuits to have considered the issue since this Court's decision in *Gonzaga University v. Doe*, 536 U.S. 273 (2002), concluded that this provision does not confer any "rights" on Medicaid providers or recipients that are enforceable under 42 U.S.C. § 1983, and respondents do not contend otherwise. Nonetheless, in the present cases, the Ninth Circuit held that § 1396a(a)(30)(A) preempted several state laws that could have the effect (either directly or indirectly) of reducing Medicaid reimbursement payments to providers, because the California Legislature failed to conduct a specific type of study that the Ninth Circuit said was required.

The questions presented are:

1. Whether Medicaid recipients and providers may maintain a cause of action under the Supremacy Clause to enforce § 1396a(a)(30)(A) by asserting that the provision preempts a state law that may reduce reimbursement rates.

QUESTIONS PRESENTED – Continued

2. Whether a state law that could result in reduced Medicaid reimbursement to providers may be held preempted by § 1396a(a)(30)(A) based on requirements that do not appear in the text of the statute.

LIST OF PARTIES

Petitioners are David Maxwell-Jolly, Director of the California Department of Health Care Services; John A. Wagner, Director of the California Department of Social Services; and Arnold Schwarzenegger, Governor of the State of California.

California Pharmacists respondents are California Pharmacists Association; California Medical Association; California Dental Association; California Hospital Association; California Association for Adult Day Services; Marin Apothecary, Inc., DBA Ross Valley Pharmacy; South Sacramento Pharmacy; Farmacia Remedios, Inc.; Acacia Adult Day Services; Sharp Memorial Hospital; Grossmont Hospital Corporation; Sharp Chula Vista Medical Center; Sharp Coronado Hospital and Healthcare Center; Fey Garcia; Charles Gallagher.

Independent Living respondents are Independent Living Center of Southern California, Inc.; Jerry Shapiro, Pharm. D., DBA Uptown Pharmacy & Gift Shoppe; Sharon Steen, DBA Central Pharmacy; Tran Pharmacy, Inc., a California Corporation.

Dominguez respondents are Lydia Dominguez; Patsy Miller; Alex Brown, by and through his mother and next friend Lisa Brown; Donna Brown; Chloe Lipton, by and through her conservator and next friend Julie Weissman-Steinbaugh; Herbert M. Meyer;

LIST OF PARTIES – Continued

Leslie Gordon; Charlene Ayers; Willie Beatrice Sheppard; Andy Martinez; Service Employees International Union United Healthcare Workers West; Service Employees International Union United Long-Term Care Workers; Service Employees International Union Local 521; and Service Employees International Union California State Council.

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PETITION FOR A WRIT OF CERTIORARI

The Attorney General of the State of California, on behalf of David Maxwell-Jolly, Director of the California Department of Health Care Services (DHCS), John A. Wagner, Director of the California Department of Social Services (DSS), and Arnold Schwarzenegger, Governor of the State of California, respectfully petitions for a writ of certiorari to review four judgments of the United States Court of Appeals for the Ninth Circuit.

OPINIONS BELOW

This petition seeks review of four opinions issued by a single panel of the Ninth Circuit Court of Appeals on March 3, 2010. Two of the opinions were designated for publication, App., *infra*, 1 (*Cal. Pharm. II*) and App., *infra*, 59 (*Dominguez*), but have not yet been reported, and two of the opinions were not designated for publication. App., *infra*, 37 (*Cal. Pharm. III*) and 53 (*Independent Living IV*). In one of the appeals (*Cal. Pharm. III*), the Ninth Circuit previously had issued an order granting an injunction pending appeal, App., *infra*, 42 (*Cal. Pharm. I*), which is reported at 563 F.3d 847. Three of the district court opinions that led to the Ninth Circuit decisions, App., *infra*, 84, 106, and 128, are reported at, respectively, 630 F. Supp. 2d 1144, 630 F. Supp. 2d 1154, and 603

F. Supp. 2d 1230, while the remainder are unreported. App. *infra*, 152, 161, 176, 178, 180.

STATEMENT OF JURISDICTION

The Ninth Circuit issued the four opinions on March 3, 2010. App., *infra*, at 1, 37, 53, 59. Petitioners have not petitioned for rehearing or rehearing en banc. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The Supremacy Clause of the United States Constitution states:

> This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

U.S. Const. art. VI, cl. 2.

The Medicaid Act, 42 U.S.C. § 1396a(a)(30)(A), states in pertinent part:

(a) Contents

A State plan for medical assistance must –

* * *

(30)(A) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area. . . .

INTRODUCTION

The present petition raises substantially the same legal issues as the petition for certiorari pending in *Maxwell-Jolly v. Independent Living Center of Southern California*, No. 09-958 (*Independent Living*). Those issues are (1) whether 42 U.S.C. § 1396a(a)(30)(A), a federal Medicaid statute that does not meet the criteria for private enforcement under 42 U.S.C. § 1983, may nonetheless be enforced against a state by private parties under a Supremacy Clause theory; and (2) whether a state statute that reduces Medicaid reimbursement to providers may be held preempted by § 1396a(a)(30)(A) based on criteria that do not appear anywhere in the statute.

In *Independent Living*, the primary basis for the Ninth's Circuit's preemption holding was the State's purported failure, before implementing a rate reduction, to conduct a study of the potential impact of Medicaid reimbursement reductions in light of the § 1396a(a)(30)(A) factors, and to study providers' costs in order to ensure that the reduced rates would bear a reasonable relationship to those costs. *Indep. Living Ctr. of S. Cal., Inc. v. Maxwell-Jolly*, 572 F.3d 644 (9th Cir. 2009) (*Indep. Living II*), *petition for cert. filed* (U.S. Feb. 16, 2010) (No. 09-958); *see also Indep. Living Ctr. of S. Cal., Inc. v. Shewry*, 543 F.3d 1050 (9th Cir. 2008) (*Indep. Living I*), *cert. denied*, 129 S. Ct. 2828 (2009) (holding that such claims could proceed under the Supremacy Clause). However, § 1396a(a)(30)(A) and its implementing regulations do not mention (let alone require) such a study, nor do they require any specific relationship between reimbursement payments and providers' costs. Moreover, the Ninth Circuit's analysis and holdings conflict with those of virtually every other circuit to have addressed these issues, namely, the First, Third, Fifth, Seventh, and Eighth Circuits.

In the present cases, the Ninth Circuit expanded its already atextual requirement of a study, holding, *inter alia*, that (1) a state must conduct a study of any reimbursement reduction not merely before implementing it, but also before *enacting* it (even though prior Ninth Circuit case law had permitted a reduction to be implemented while the requisite study was being conducted, *see Orthopaedic Hosp. v. Belshe*, 103

F.3d 1491, 1494 (9th Cir. 1997), *cert. denied*, 522 U.S. 1044 (1998)); (2) the state *legislature*, rather than the relevant state agency, must conduct the study if the legislature was the entity responsible for imposing the reduction (so that formal, pre-enforcement studies conducted by DHCS could not discharge the State's purported duties under § 1396a(a)(30)(A)); (3) the study must *expressly reference both § 1396a(a)(30)(A) and the specific statutory enactment* at issue (so that a study prepared expressly for the state legislature that provides data from which the legislature could make an informed decision about a reduction, but that does not include the purportedly necessary express references, does not suffice); (4) a study prepared specifically for a state legislature does not suffice unless the state *produces evidence that the legislature actually considered it*, and that evidence must consist of more than a reference to the study in a legislative committee agenda; and (5) a state must study providers' costs prior to implementing any reduction even if a particular class of providers does not incur costs in providing their services, and must create a means for obtaining cost data if no such means already exists; however, if no provider cost data exists, a state may use a proxy, but the court may second-guess (and reject) the choice of proxy.

The Ninth Circuit issued these holdings in the context of challenges to two statutory enactments that occurred subsequent to the enactment at issue in *Independent Living*. *Independent Living* involves the Assembly Bill ("AB") 5 reductions: ten percent

across-the-board reductions in Medicaid reimbursement payments enacted in February 2008 to apply to services provided under Medi-Cal's[1] fee-for-service program on or after July 1, 2008 (the "AB5" reductions). App., *infra*, 190. As described below, the present petition involves two later enactments: (1) the "AB1183" reductions, enacted in September 2008 to replace the AB5 reductions, App., *infra*, 198; and (2) Senate Bill X3 6 ("SB6"), which concerns the State's contribution toward the hourly wage and benefits paid by counties to providers of In-Home Supportive Services (IHSS). App., *infra*, 218. On March 3, 2010, the Ninth Circuit panel that previously affirmed the injunctions in *Independent Living* also affirmed all the injunctions sought here (and in one case, *California Pharmacists III*, reversed the district court by ordering entry of an injunction that the court had declined to grant). App., *infra*, 1, 37, 53, 59.

As petitioner Maxwell-Jolly demonstrated in the *Independent Living* petition, the Ninth Circuit's decision to allow private enforcement of § 1396a(a)(30)(A), coupled with its willingness to impose ever-expanding atextual requirements, has created a new class of lawsuits that is wreaking havoc with California's ability to manage its $40 billion Medicaid budget and its ability to plan its way out of its budget crisis through sensible Medicaid reform. Untethered from

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[1] California's Medicaid program is known as Medi-Cal.

any statutory or regulatory language, the rules announced by the Ninth Circuit keep changing, and they become more onerous with each iteration. Congress put an administrative agency, rather than the courts, in charge of Medicaid for a reason: to work with the states on an ongoing basis, with regular communication and guidance, to ensure that they understand and comply with Medicaid requirements. Court-imposed injunctions, issued in private suits based on judicially-created, atextual requirements, that subject the States to massive liability, undermine Congressional intent and the cooperative federalism that is supposed to animate the program. These issues are important, recurring, national in scope, and the subject of conflicting and erroneous decisions among the circuits (as demonstrated in the *Independent Living* petition), and therefore merit review.

STATEMENT OF THE CASE

On September 30, 2008, the Governor signed the AB1183 reductions into law. App., *infra*, 198. AB1183 enacted a new, substitute set of smaller reductions to take the place of the AB5 reductions starting on March 1, 2009. Specifically, it, *inter alia*, (1) replaced the prior 10% reduction applicable to payments to physicians, dentists, optometrists, and clinics under Medi-Cal's fee-for-service program with a smaller, 1% reduction for dates of service on or after March 1, 2009; (2) replaced the prior 10% reduction for

payments to Adult Day Health Centers (ADHCs) and pharmacies under Medi-Cal's fee-for-service program with a smaller, 5% reduction for dates of service on or after March 1, 2009; (3) replaced the prior 10% reduction applicable to payments to hospitals for outpatient services with a smaller, 1% reduction for dates of service on or after March 1, 2009; and (4) replaced the prior 10% reduction applicable to payments to hospital-based nursing facility services and hospital-based subacute care services with a smaller, 5% reduction for dates of service on or after March 1, 2009. AB1183 also repealed all payment reductions for small and rural hospitals effective November 1, 2008, and enacted a new reimbursement cap on payments to some noncontract hospitals for inpatient services provided on or after October 1, 2008. App., *infra*, 201-16; Cal. Welf. & Inst. Code §§ 14105.191(b)(1)-(3), 14166.245(b), (c).[2]

The Legislature directed DHCS to "promptly seek any necessary federal approvals for the implementation" of the reductions. App., *infra*, 205, 210, 215; Cal. Welf. & Inst. Code §§ 14105.19(g), 14105.191(h),

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[2] Specifically, payments for inpatient services provided by noncontract hospitals, other than small and rural hospitals, are subject to a 10% reduction under AB1183; in addition, those noncontract hospitals located in a Health Facility Planning Area (HFPA) with a specified minimum number of general acute care hospitals have their reimbursements capped at an average of rates paid to hospitals under contract with the State minus 5% ("CMAC-5%"). App., *infra*, 211, 214; Cal. Welf. & Inst. Code §§ 14166.245(b)(2)(A), (c)(3)(B).

14166.245(f). However, it authorized DHCS to "elect not to implement" the reductions on payments to fee-for-service providers if "federal financial participation is not available with respect to any payment" subject to the reductions. App., *infra*, 210; Cal. Welf. & Inst. Code § 14105.191(h). And it ordered DHCS and the California Medical Assistance Commission (CMAC) to report annually regarding the implementation and impact of the reductions on payments for inpatient services provided by noncontract hospitals. App., *infra*, 215-16; Cal. Welf. & Inst. Code § 14105.191(i).

On September 30, 2008, DHCS submitted a State Plan Amendment (SPA) to the federal Centers for Medicare and Medicaid Services (CMS), which remains pending. That SPA encompassed the AB5 reductions and most of the superseding AB1183 reductions. *See* App., *infra*, 27.[3]

AB1183 prompted two of the lawsuits at issue, which were brought by different sets of providers: *California Pharmacists Association v. Maxwell-Jolly* and *Independent Living Center of Southern California v. Maxwell-Jolly* (*Independent Living IV*). A separate enactment, SB6, prompted a third lawsuit, *Dominguez v. Schwarzenegger*. Each is described in turn.

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[3] In response to a request from CMS, DHCS subsequently split the September 30, 2008 SPA into four separate SPAs that it submitted on October 29, 2008. DHCS submitted a separate SPA to encompass the AB1183 reductions for noncontract hospital inpatient services on December 31, 2008.

California Pharmacists v. Maxwell-Jolly

On January 29, 2009, Medicaid provider groups and beneficiaries filed *California Pharmacists Association v. Maxwell-Jolly* to enjoin the 1% and 5% reductions applicable to fee-for-service providers, including pharmacies, ADHCs, and hospital-based nursing facilities and subacute care facilities, and the new (CMAC-5%) reimbursement cap on inpatient services provided by certain noncontract hospitals. *See* App., *infra*, 205-06, 211, 214; Cal. Welf. & Inst. Code §§ 14105.191(b)(1)-(3), 14166.245(b)(2)(A), (c)(3)(B). Respondents moved for preliminary injunctions shortly thereafter. In opposing the motions, DHCS submitted a broad array of evidence concerning the legislative process that led to the enactments and analyzing the adequacy of the reduced rates.

Declarations described the California Legislature's deliberative process in enacting AB1183. Starting in January 2008, top-ranking DHCS officials in charge of Medi-Cal met with the Governor's Office and members of the Legislature to discuss the options available for reducing the ever-increasing costs of the Medi-Cal program. The more moderate proposed reductions ultimately enacted by AB1183 were considered and discussed in legislative committee meetings in May, June, and July 2008, as documented in committee reports and agendas. App., *infra*, 18-20, 98, 119. A sworn declaration from DHCS's Deputy Director for Legislative and Governmental Affairs described how DHCS staff members provided information, technical assistance, and responses to numerous

inquiries from legislative staff members concerning the reductions from May 2008 until AB1183 was enacted in September 2008. App., *infra*, 18. Ultimately, the Legislature and Governor were able to avoid taking more draconian measures, such as eliminating all optional Medi-Cal benefits including pharmacy services (which cost Medi-Cal in excess of $3 billion per year)[4] or restricting beneficiaries' eligibility for Medi-Cal.

Cognizant of the Ninth Circuit's prior rulings in *Independent Living I* and *Orthopaedic*, following AB1183's enactment but before its implementation, DHCS conducted formal cost-based evaluations with respect to those services for which it could obtain relevant cost data. Based in part on these evaluations, DHCS prepared a series of formal reports analyzing the potential impact of each of the AB1183 reductions, which it released in February 2009, before most of the AB1183 reductions took effect on March 1, 2009.[5] DHCS concluded in these reports, based on its

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[4] "Optional" benefits are those that, under the Medicaid Act, a state may, but is not required, to provide. California eliminated coverage for some optional benefits effective July 1, 2009, but preserved coverage for ADHC services, prescription drugs, substance abuse treatment services, licensed midwife services, hearing aids, Personal Care Services Program, and other services.

[5] By statute, the AB1183 reduction applicable to certain noncontract hospitals' inpatient services was implemented in October 2008, before the other AB1183 reductions. Therefore, one study, "Amended Analysis: Impact of Welfare and Institutions Code Section 14166.245 Concerning Medi-Cal Reimbursement

(Continued on following page)

analysis and the data available to it, that the reduced payments would comply with federal law, reasonably compensate providers' costs, increase efficiency in Medi-Cal, and not impair beneficiaries' access to services. Although the methods and data used in each analysis varied, DHCS noted in *all* the reports that, during the period in which the higher 10% reductions were in effect, there were no material declines in either claims paid or the number of providers participating in Medicaid, supporting the conclusion that the new, far-smaller reductions were unlikely to disrupt the system. *See, e.g.*, App., *infra*, 100.

ADHCs. DHCS submitted a February 24, 2009 report entitled "Analysis of Assembly Bill 1183 Medi-Cal Reimbursement for Adult Day Health Care Centers." *See* App., *infra*, 96-97, 99-100. In the report, DHCS concluded that reimbursement to ADHCs, as reduced by AB1183, would be sufficient to cover at least 100% of their necessary and reasonable costs and would not result in any access problem. *See* App., *infra*, 97, 99. DHCS based its analysis in part on cost data for nursing (level A) facilities (NF-As) because, as it explained, it does not have access to reliable cost data for ADHCs.[6] App., *infra*, 99 n.6. Instead,

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for Non-Contract Hospital Inpatient Services," described in more detail below, was issued after the implementation date for the relevant reduction.

[6] Due to recent state legislation, DHCS is developing a cost-based reimbursement methodology for such entities that will be effective August 1, 2012. *See* Cal. Welf. & Inst. Code §14571.2; App., *infra*, 99 n.6

pursuant to a court settlement to which ADHCs were a party, on August 1, 1997, the Medi-Cal reimbursement daily rate for ADHCs was set at 90% of the statewide weighted average of the Medi-Cal daily rate for NF-As (who are reimbursed at least 100% of their costs), although due to subsequent adjustments, the relationship is now closer to 87%. For context, ADHCs typically provide only four hours of services a day to a population that is far more ambulatory and independent than the population served by NF-As, which generally requires 24-hour nursing care in an institutional setting. Moreover, there has been a threefold increase in ADHCs since 1997, when their reimbursement rates were linked to NF-As.

Hospital-Based Nursing Facility and Subacute Care Services. DHCS submitted a February 24, 2009 Report, entitled "Analysis of Assembly Bill 1183 Medi-Cal Reimbursement for Various Nursing Facility Services." This was a 12-page report with supporting material. Based on a study of costs incurred by these providers, DHCS determined that, after a 5% reduction, reimbursement would compensate in the aggregate 86-92% of costs incurred by adult subacute care providers, 104-109% of the costs incurred by pediatric subacute care providers, and 83-85% of costs incurred by hospital-based nursing facility (level B, or NF-B) providers. DHCS noted that, with respect to NF-B services, other providers that are not subject to the AB1183 reductions (i.e., freestanding nursing facilities) currently provide 94% of such services at about half the expense.

Noncontract Hospitals Inpatient Services. DHCS produced a February 19, 2009 report entitled "Amended Analysis Impact of Welfare and Institutions Code Section 14166.245 Concerning Medi-Cal Reimbursement for Non-Contract Hospital Inpatient Services." App., *infra*, 117. This was a 16-page report with 130 pages of supporting material.[7] In the report, DHCS concluded that, after the AB1183 reductions, Medi-Cal reimbursement would compensate in the aggregate 91% of the costs incurred by all noncontract hospitals, with many noncontract hospitals being reimbursed 100% or more of their costs.[8] DHCS explained, further, that the reductions would incentivize noncontract hospitals to enter into contracts with the State, resulting in tremendous cost efficiencies. While noncontract hospitals provide approximately 11% of inpatient days, they receive 21.9% of Medi-Cal reimbursement for hospital inpatient services. The State saved $572 million in the 2007-2008 fiscal year due to the reduced rates it pays to contract hospitals, and has saved over $10.3 billion in general fund expenditures since 1983. DHCS also concluded that the reductions would not create patient access problems, in part because contract hospitals that are

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[7] The February 19, 2009 report corrected errors in the original report issued on January 29, 2009.

[8] Many noncontract hospitals receive, in addition to the reimbursement paid pursuant to AB1183, supplemental Medi-Cal reimbursement under the disproportionate share hospital (DSH) program. AB1183 did not reduce Medi-Cal money paid to noncontract hospitals under the DSH program.

not subject to the AB1183 reductions on inpatient services provide 89-90% of those services under Medi-Cal. *See* App., *infra*, 125-26.

Hospital Outpatient Services. DHCS did not prepare a formal report analyzing AB1183's impact on outpatient services, instead submitting declarations and supporting documents. Based on historical claims data (including the claims and participation data for when the 10% reduction was in effect), DHCS demonstrated that the 1% reduction mandated by AB1183 would not reduce Medicaid beneficiaries' access to such services.

DHCS did not analyze how the reduced rates would compare to providers' costs in providing outpatient services because, as it explained, there is no feasible mechanism for collecting reliable cost data for each of the 20,000-plus outpatient services covered by Medi-Cal. Following the Ninth Circuit's decision in *Orthopaedic*, DHCS commissioned a consulting firm, Tucker-Alan, Inc., to develop a methodology. After two failed attempts, the outside consultant advised that development of a sufficiently reliable cost model would take 5-7 years to establish and implement. Ultimately, rather than develop a cost model, DHCS entered into a settlement agreement with the hospitals under which their outpatient reimbursement increased substantially (e.g., by 44.34% in July 2004 above what was in effect in June 2001). *See* App., *infra*, 125.

DHCS also submitted a Legislative Analyst's Office (LAO) report, "Analysis of the 2008-09 Budget Bill" (2008-09 Analysis),[9] which evaluated the 10% reduction enacted by AB5 and, *inter alia*, recommended more moderate reductions for some services (a recommendation that the Legislature ultimately followed when it enacted AB1183). The LAO is a nonpartisan entity, operating under the oversight of the Joint Legislative Budget Committee, to "provid[e] fiscal and policy advice to the Legislature." *See* http://www.lao.ca.gov/laoapp/laomenus/lao_menu_aboutlao.aspx. The LAO report recommended increased reductions for hospitals on the ground that they have "received significant rate increases relative to other provider types in recent years, and hospitals are generally among the most expensive settings to provide care." App., *infra*, 125. The Legislature followed that recommendation by enacting lower rates for some noncontract hospitals, although it eliminated any reduction for small and rural hospitals.

On March 9, 2009, in *California Pharmacists*, the district court enjoined the 5% reduction on ADHCs, App., *infra*, 84, but refused to enjoin the AB1183 reductions as to inpatient, outpatient, and other services provided by hospitals, holding that plaintiffs had failed to carry their burden on irreparable harm. App., *infra*, 106. The district court held that plaintiffs

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[9] The LAO's 2008-09 Analysis is available at http://www.lao.ca.gov/analysis_2008/health_ss/healthss_anl08.pdf.

had demonstrated a likelihood of success on *all* their claims based on the State's failure to discharge a purported duty under § 1396a(a)(30)(A), as interpreted by the Ninth Circuit, to study the impact of any rate reduction before the reduction is enacted. App., *infra*, at 98-99, 120. The district court specifically faulted DHCS's formal study on ADHCs for utilizing NF-A data, "which may not be an adequate proxy for ADHC costs." App., *infra*, 99. While the court recognized that the LAO report supported the reductions for noncontract hospitals, the court held it was insufficient because "defendant presents no evidence to indicate that the Legislature actually reviewed or considered the LAO's report in passing AB1183." App., *infra*, at 119 n.8.

After the district court denied their motion for a preliminary injunction based on their failure to demonstrate irreparable harm, the hospital plaintiffs filed an emergency motion for a preliminary injunction pending appeal in the Ninth Circuit. On April 6, 2009, the Ninth Circuit granted an injunction pending appeal. App., *infra*, 42 (*Cal. Pharm. I*). It agreed that the hospitals had demonstrated a likelihood of success on the merits given the State's failure to show that the Legislature considered the § 1396a(a)(30)(A) factors before passing AB1183. App., *infra*, 44-45. Specifically, it found no abuse of discretion in the district court's holdings that (1) DHCS's formal studies were impermissibly post hoc; and (2) evidence that the LAO had recommended enactment of the rate reductions was inadequate because "there was

no evidence that the Legislature actually considered the report before enacting AB1183." App., *infra*, 44-45. In addition, the court found that respondents had demonstrated irreparable injury given that the Eleventh Amendment would bar them from obtaining retroactive monetary damages were they ultimately to prevail in the case. App., *infra*, 50.

On March 3, 2010, the Ninth Circuit issued opinions affirming the injunctions of the payment reductions for ADHCs (*Cal. Pharm. II*), and reversing the denial of an injunction of payment reductions for noncontract hospitals (*Cal. Pharm. III*). App., *infra*, 1, 37. The Ninth Circuit emphasized that, under *Independent Living II*, the State must produce evidence that it studied the impact of any rate reduction on the § 1396a(a)(30)(A) factors *before* the reduction either is enacted *or* implemented, and that the State relied upon responsible cost data in setting rates. App., *infra*, 3, 15-17, 36. Further, the court held that, because the California Legislature was the entity that mandated the payment reductions, it, rather than DHCS, was the entity that "must engage in the same principled analysis we required of the Director in *Orthopaedic II*." App., *infra*, 13-14; *see also* App., *infra*, 16-17 ("[W]e find nothing remarkable in holding that the final body responsible for setting Medicaid reimbursement rates must study the impact of the contemplated rate reduction on the statutory factors . . . *prior* to setting or adjusting payment rates.").

Despite uncontroverted evidence that the California Legislature had considered and discussed the AB1183 rate reductions before enacting them, the court held that the State failed to demonstrate that the Legislature had discharged its obligations under § 1396a(a)(30)(A). The court noted that, while the agendas and other legislative documents provided by DHCS referenced the specific rate reductions, they did not expressly reference the § 1396a(a)(30)(A) factors, and therefore could not serve as evidence that the Legislature expressly considered those factors. App., *infra*, 20 ("[T]he legislative history nowhere mentions any of the § 30(A) factors."). In addition, according to the panel, there was no evidence that the Legislature relied on "'"responsible cost studies, its own or others,"'" as a basis for its rate-setting. App., *infra*, 20-21 (quoting *Independent Living II* and *Orthopaedic*).

The court rejected as inadequate the post-enactment, but largely pre-implementation, formal studies that DHCS released in February 2009. It explained that, "[t]o satisfy § 30(A), any analysis of reimbursement rates . . . must have the potential to influence the rate-setting process." App., *infra*, at 22. The post-enactment studies could not suffice because, according to the court, AB1183 was phrased in mandatory terms and did not give DHCS discretion *not* to implement the rates based on the results of its analysis. App., *infra*, 22. The court rejected DHCS's arguments that, under federal and state law, as the designated "single state agency" entrusted with

implementing Medicaid, it could have declined to implement the reductions pursuant to California Welfare and Institutions Code sections 14105(a) and 14105.191(i). App., *infra*, 22-26; *see also* 42 U.S.C. § 1396a(a)(5).

With respect to ADHCs, the panel held that the district court did not abuse its discretion in rejecting NF-A cost data as a proxy for ADHC cost data, App., *infra*, 29, even though reliable ADHC cost data was not available to DHCS when it conducted its analysis, and even though ADHCs reimbursement rates have been tied to NF-A reimbursement rates since 1997.

Independent Living v. Maxwell-Jolly (*Independent Living IV*)

On January 16, 2009, a group of pharmacy plaintiffs filed a lawsuit, *Managed Pharmacy Care v. Maxwell-Jolly*, to enjoin a 5% rate reduction for pharmacy services rendered on or after March 1, 2009 under Medi-Cal's fee-for-service program, pursuant to AB1183. *See* App., *infra*, 206; Cal. Welf. & Inst. Code § 14105.191(b)(3). Shortly thereafter, respondents moved for a preliminary injunction.

DHCS produced a wide array of evidence to oppose this injunction, including much of the same legislative material it provided in *California Pharmacists*. Of particular relevance to the pharmacy reductions, DHCS produced an agenda for a May 30, 2008 meeting of the Assembly Budget Subcommittee No. 1 on Health and Human Services that expressly

referenced a pharmaceutical cost-data study (the "Myers and Stauffer" study). App., *infra*, 55.

In addition, DHCS produced its February 8, 2009 report entitled "Analysis of Assembly Bill 1183 Medi-Cal Reimbursement for Pharmacies." App., *infra*, 141. This was a 13-page report with over 150 pages of supporting material. Included among them was the above-referenced Myers and Stauffer report, an analysis of drug dispensing and acquisition costs incurred in California prepared by an outside accounting firm that specializes in Medicaid issues. Based on this report, and adjusting for inflation, DHCS concluded that, as of March 1, 2009, Medi-Cal would reimburse drugs in the aggregate (i.e., single source drugs and multisource drugs) at 108.7% of costs without the AB1183 reductions, and at 103% of costs after the reductions were imposed (98.9% of costs for single source drugs, and up to 137% of costs for multisource drugs). *See* App., *infra*, 147, 159. More efficient pharmacies would do even better. There would be no access problem, as 5,772 of the 6,078 pharmacies in California with active licenses are actively enrolled in Medi-Cal.

On February 27, 2009, the district court enjoined the 5% reduction on payments for prescription drugs. App., *infra*, 128; *see also* App., *infra*, 152 (denying motion to alter or amend, and clarify prior order). The district court's analysis was substantially the same as that in its *California Pharmacists* decision described above.

On March 3, 2010, the Ninth Circuit affirmed the district court's order enjoining the AB1183 reduction for pharmacies. App., *infra*, 53. It reiterated much of the reasoning from its *California Pharmacists* opinion with respect to the purported requirement of a *pre-enactment* study conducted by the state *legislature*. App., *infra*, 54, 57. Although it acknowledged the express mention of the Myers and Stauffer report in the budget committee agenda, the court rejected this evidence as inadequate under § 1396a(a)(30)(A): "the one-sentence citation to the May 30, 2008 agenda does not show adequate consideration of the § 30(A) factors." App., *infra*, 55-56. The court also found the Myers and Stauffer report inadequate because "it is bereft of any analysis of the remaining § 30(A) factors – efficiency, economy, quality, and access to care." App., *infra*, 56.

Dominguez v. Schwarzenegger

In February 2009, the Governor signed the SB6 reductions into law. App., *infra*, 218. Effective July 1, 2009, SB6 would have reduced an existing cap on the State's maximum contribution to wages and benefits paid by the counties to IHSS providers as part of Medi-Cal. App., *infra*, 224; Cal. Welf. & Inst. Code § 12306.1(d)(6).

The IHSS program provides payment for services such as cleaning, personal care services, accompaniment for necessary travel to health-related appointments, and protective supervision, to low-income,

aged, blind and disabled persons. *See* Cal. Welf. & Inst. Code § 12300. The IHSS program is administered by the California counties, and the wages paid to IHSS providers are generally governed by collective bargaining agreements negotiated by the counties with unions representing IHSS providers, to which the State is not a party. App., *infra*, 63-64, 163-64. Because they are separately negotiated, the rates paid for IHSS wages vary from county to county. The State contributes 65% of the nonfederal share of wage and benefits paid to IHSS providers, up to a statutory cap, which was $12.10 per hour before SB6 was enacted (the counties pay the remaining 35% of the nonfederal share). App., *infra*, 65, 163-64.

Under SB6, the statutory cap toward which the State was to contribute would have been reduced from $12.10 to $10.10 per hour effective July 1, 2009. App., *infra*, 65, 224; Cal. Welf. & Inst. Code § 12306.1(d)(6). This amendment would not have affected the majority of counties or the majority of IHSS providers: before the Legislature enacted SB6, 36 of the State's 58 counties already paid IHSS providers $10.10 or less per hour in wages and benefits, including Los Angeles County, where 42% of all IHSS services are provided. *See* App., *infra*, 66, 164-65. Further, counties always have had the option of paying more than the maximum amount to which the State will contribute, and would have been free to do so in this instance, using their own funds as necessary to pay the nonfederal share. App., *infra*, 66, 164.

Respondent unions and Medi-Cal beneficiaries filed *Martinez v. Maxwell-Jolly*, on May 26, 2009, challenging implementation of the new cap. They contended that the new cap was preempted by § 1396a(a)(30)(A) because the State purportedly failed to study its impact before enacting it.

Petitioners conceded that the Legislature had not specifically conducted a study analyzing the impact of SB6 on the § 1396a(a)(30)(A) factors before the reductions were enacted. The new participation cap was, after all, equal to or higher than the wages and benefits already in effect in most of the State. Petitioners noted, however, that when the Legislature enacted SB6, it had access to the "July 2008 Report to the Legislature, Public Authorities and Nonprofit Consortia in the Delivery of In-Home Supportive Services, SFY 2006/2007" (July 2008 report), a type of report that the Department of Social Services (DSS) must submit on an annual basis. App., *infra*, 78, 80. In the words of the Ninth Circuit, this report contained "extensive data regarding quality and access in the IHSS system," App., *infra*, 78, including data on the number of providers available to work in the provider registries in each county; data on service shortages and the availability of emergency back-up providers; and data on wages and benefits paid by each county.

On June 25, 2009, the district court enjoined the reduced cap imposed by SB6. App., *infra*, 161, 176; *see also* App., *infra*, 178, 180 (amended injunction, order clarifying injunction). It, too, cited petitioners' failure

to produce evidence demonstrating that the California Legislature considered the § 1396a(a)(30)(A) factors when it adopted the new cap. App., *infra*, 171-72. The district court also found that respondents met their burden to show irreparable harm based on evidence that, were the rates reduced, IHSS providers might leave the program, possibly leaving some beneficiaries with reduced services. App., *infra*, 172-73.

On March 3, 2010, the Ninth Circuit affirmed the injunction in an opinion at issue here. App., *infra*, 59 (*Dominguez*). The court recognized that SB6 does not directly reduce IHSS wages, but merely may lower the State's contribution to those wages. App., *infra*, 70. Nonetheless, the court held that, "before enacting legislation that has the effect of lowering payments to providers . . . the State must study the impact of the decision on the statutory factors set forth in §30(A)." App., *infra*, 70 (citing *Cal. Pharm. II*). The court rejected petitioners' arguments that they could not study IHSS providers' costs because such providers do not incur costs. The court held that, where the court has previously required a cost study, the State is not immunized from liability simply because it has no mechanism for collecting such costs (or, apparently, even though such costs do not exist). App., *infra*, 77. Instead, the court said the state "must rely on something." App., *infra*, 78. It therefore suggested that the State "look to what it costs providers of analogous services, such as in-home nursing care, as a means of considering providers' costs." App., *infra*,

78-79. Although the State demonstrably did rely on "something" in defending SB6 in its Ninth Circuit briefing – specifically the July 2008 report to the Legislature – the court held that this too was inadequate to discharge the State's duties under § 1396a(a)(30)(A) because it did not specifically reference SB6, "let alone 'study the impact of the contemplated rate change(s) on the statutory factors *prior to* setting rates, or in a manner that allows those studies to have a meaningful impact on rates before they are finalized.'" App., *infra*, 80 (quoting *Cal. Pharm. II*).

The court also rejected petitioners' arguments that SB6 would not result in an access problem, noting that under its prior decisions, the obligations under § 1396a(a)(30)(A) are purely "procedural." App., *infra*, 76. It thereby reaffirmed its holding in *Independent Living II* that a state law may be enjoined solely because the State failed to conduct a particular kind of study, regardless of whether the measure complies "substantively" with federal law, and despite the fact that neither § 1396a(a)(30)(A) nor its implementing regulations requires such a study.

REASONS FOR GRANTING THE PETITION

1. The Court should grant the petition to consider whether a private party may bring a preemption challenge under a Spending Clause statute, 42 U.S.C. § 1396a(a)(30)(A), that is not otherwise

enforceable by private parties under 42 U.S.C. § 1983. This issue is already pending before this Court in the petition for certiorari filed in *Independent Living II* and *III*, No. 09-958.

Under the reasoning adopted by the Ninth Circuit, a private party may seek to enforce any federal statute, and enjoin state conduct, merely by invoking the Supremacy Clause and alleging a conflict between state and federal law. A party pursuing such a theory need not satisfy any of the requirements for private enforcement of federal statutes that this Court has carefully crafted and applied over several decades, such as the requirement that the party demonstrate that Congress intended to create a privately enforceable federal "right," and that the provision to be enforced is not so "vague and amorphous" as to strain judicial competence. *See, e.g., Cort v. Ash*, 422 U.S. 66 (1975); *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1 (1981); *Gonzaga Univ. v. Doe*, 536 U.S. 273 (2002).

The Ninth Circuit's theory (which the D.C., Fifth, and Eighth Circuits also have accepted[10]) has opened the door to a flood of lawsuits seeking to enjoin state action based on federal Spending Clause provisions

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[10] *See Planned Parenthood of Houston & Se. Tex. v. Sanchez*, 403 F.3d 324, 330-35 (5th Cir. 2005); *Lankford v. Sherman*, 451 F.3d 496, 509-13 (8th Cir. 2006); *see also Pharmaceutical Res. & Mfrs. of Am. (PhRMA) v. Thompson*, 362 F.3d 817, 819 n.3 (D.C. Cir. 2004); *cf. PhRMA v. Concannon*, 249 F.3d 66, 73 (1st Cir. 2001).

that previously have been held by the courts to be unenforceable by private parties under § 1983, including 42 U.S.C. §§ 1396a(a)(17) and 1396a(a)(30)(A). *See* App., *infra*, 228. One recent lawsuit even sought to invoke *Independent Living* and the Supremacy Clause to state a claim under a purely hortatory "purposes" provision of the American Recovery and Reinvestment Act of 2009, H.R. 1, 111th Cong., Pub. L. No. 111-5 (1st Sess. 2009), § 5000(a). *Gray Panthers of San Francisco v. Schwarzenegger,* No. C 09-2307 PJH, 2009 WL 2880555 (N.D. Cal. Sept. 01, 2009).

Recent developments, including the four new opinions at issue here, confirm both the recurring nature and national importance of the question presented. As reflected in the updated information included in the Appendix, App., *infra*, 228, the Ninth Circuit's *Independent Living* decisions have generated almost 40 new lawsuits across the country, including in Arizona, Connecticut, Delaware, Hawai'i, Idaho, Kansas, Louisiana, Maine, Minnesota, New York, Pennsylvania, and Washington. California's liability under existing injunctions is fast approaching $1 billion, consisting of over $735 million in lost Medicaid savings to date, and more than $250 million in additional retroactive relief to which providers in *Independent Living* contend they are entitled. App., *infra*, 228-32. The existing injunctions are costing over $35 million in additional lost Medicaid savings each month that they remain in place. App., *infra*, 228-32. More can be expected: in the short time since

petitioner Maxwell-Jolly filed the petition for certiorari in *Independent Living* in February 2010, two more courts in California have issued injunctions based on the Ninth Circuit's interpretation of the Supremacy Clause. App., *infra*, 228, 229.

Petitioners believe that *Independent Living* is a suitable vehicle for deciding this first question presented, as the Ninth Circuit chose that opinion to announce its holding and analysis. Moreover, the Ninth Circuit declined to revisit this issue in the four March 3, 2010 opinions at issue here, apparently believing that its earlier decisions in *Independent Living I, II,* and *III* resolved it. However, as DHCS has noted, while the petition for certiorari in *Independent Living* presents a live case or controversy, the state statute at issue in those decisions is no longer in effect, having been replaced with the lower (AB1183) reductions at issue here.[11] Therefore, if this Court would prefer to decide the question presented with respect to reductions that are still in effect, the present petition presents an excellent vehicle for doing so. Petitioners properly preserved this first

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[11] The petition in *Independent Living* presents a live controversy because, if the State prevails, it will be entitled to retroactive reimbursement of excess Medicaid reimbursements that it was required to pay providers as a result of the injunctions at issue in that case.

question presented in both *Dominguez* and *Independent Living IV*.[12]

2. The Court also should grant the petition to consider whether state statutes that directly (or, at best, indirectly in the case of SB6) reduce Medicaid reimbursement payments to certain providers may be preempted based on requirements that do not appear in the text of the preempting federal statute, § 1396a(a)(30)(A). This issue, too, is already pending before this Court in the *Independent Living* petition for certiorari, No. 09-958.

In *Independent Living*, the Ninth Circuit held that the AB5 reductions were preempted because California failed to provide evidence that, "before implementing those cuts," it (1) studied the impact of

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[12] In *Dominguez*, petitioners preserved this issue as presented here. In *Independent Living IV*, petitioners included this argument in a discussion in their opening brief of "prudential standing," expressly stating: "It is the Department's position that *ILC* was wrongly decided because it conflicts with numerous Supreme Court precedents, including *Gonzaga Univ. v. Doe*, 536 U.S. 273 (2002), and because the Supremacy Clause does not itself create any substantive rights. *See Dennis v. Higgins*, 498 U.S. 439, 450 (1991); *Golden State Transit Corp. v. City of Los Angeles*, 493 U.S. 33 103, 107 (1989); *Chapman v. Houston Welfare Rights Org.*, 441 U.S. 600, 615 (1979). The Department recognizes, however, that *ILC* is controlling here, and therefore raises these arguments to preserve them for later appellate proceedings." Defendant-Appellant David Maxwell-Jolly's Opening Brief and Request for Oral Argument at 32-33, *Indep. Living IV*, No. 09-55692 (9th Cir. June 19, 2009) (footnote omitted); *see also* App., *infra*, 138 n.6 & 171 n.5.

the reductions on the § 1396a(a)(30)(A) factors of efficiency, economy, quality, and access to care; and (2) considered responsible studies of providers' costs, to ensure that the reduced rates would bear a reasonable relationship to those costs. *Indep. Living II*, 572 F.3d at 648, 651-52. However, neither §1396a(a)(30)(A), nor any of its implementing regulations, requires any sort of study, let alone a pre-enactment or pre-implementation study; and neither §1396a(a)(30)(A), nor any of its implementing regulations, requires that reimbursement rates bear any relation to providers' costs. The Ninth Circuit also held that the rate reduction could be preempted because it was motivated "solely" by "budgetary concerns." *Id.* at 655-56. But § 1396a(a)(30)(A) does not preclude a state from reducing rates to address a budgetary crisis, so long as the substantive requirements of the statute are met.

In the present cases, the Ninth Circuit reaffirmed this basic framework, and then added to it. Based on the new decisions:

(1) Any study must be concluded not merely pre-implementation, but also pre-enactment (resolving an ambiguity in *Independent Living II* and *III*). App., *infra*, 15, 54, 57, 80.

(2) The actual entity that mandates the payment reductions – in this case, the California Legislature – must conduct the required study. App., *infra*, 13-14, 16, 54.

(3) Where the obligation to conduct the study falls on a state legislature rather than a state agency, there must be evidence that the legislature actually considered the requisite study. Something more than an agenda item reflecting that a budget committee studied the issue is required. App., *infra*, 55-56. A report issued by a nonpartisan entity convened by the state legislature to assist in fiscal and budgeting matters also does not suffice, absent additional evidence that the legislature considered the report. App., *infra*, 45. While the Ninth Circuit rejected this evidence, it did not indicate what *would* be adequate evidence that the Legislature had discharged its duty under § 1396a(a)(30)(A) as interpreted.

(4) Any study must expressly reference both the state enactment being analyzed (e.g., SB6, AB1183) *and* the § 1396a(a)(30)(A) factors. App., *infra*, 20, 56, 80. Thus, evidence that a state legislature considered reports or data that did not specifically reference either the reductions or § 1396a(a)(30)(A), but from which the legislature reasonably could have drawn the conclusion that the reductions would comply with federal law, does not suffice.

(5) If a state does not have a feasible means for obtaining cost data with respect to a specific type of cut, it must obtain such data or possibly rely on a reasonable proxy. App., *infra*, 78-79 (suggesting that State use in-home nursing care costs as proxy for IHSS providers, even though IHSS providers do not incur costs). However, the court may second-guess (and reject) the proxy chosen by the state. App., *infra*,

29 (suggesting that DHCS should not have used NF-A cost data as a proxy in the ADHC study, even though ADHC reimbursement rates have been tied to NF-A reimbursement rates since 1997).

In addition, the Ninth Circuit reaffirmed that, even if there is evidence that rates under the challenged state statute will remain substantively adequate under § 1396a(a)(30)(A), such evidence may be irrelevant: the statute still may be enjoined if the State failed to comply with a "procedural" requirement to produce a pre-enactment study that contains all the features set forth above. App., *infra*, 76; *see also* App., *infra*, 22.

In light of the ever-growing list of increasingly specific requirements that the Ninth Circuit has imposed under the guise of interpreting § 1396a(a)(30)(A), it is at best ironic that the court chose to "emphasize that the State need not follow 'any prescribed method of analyzing and considering [the § 30(a)] factors.'" App., *infra*, 17 (quoting *Minn. HomeCare Ass'n v. Gomez*, 108 F.3d 917, 918 (8th Cir. 1997) (per curiam)). Presumably cognizant that it is on the short side of a circuit split concerning whether states must conduct a § 1396a(a)(30)(A)-based study before implementing Medicaid rate reductions,[13] the court apparently

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[13] *Compare Long Term Care Pharmacy Alliance v. Ferguson*, 362 F.3d 50, 56 (1st Cir. 2004); *Rite Aid of Pa., Inc. v. Houstoun*, 171 F.3d 842, 851 (3d Cir. 1999); *Evergreen Presbyterian Ministries Inc. v. Hood*, 235 F.3d 908, 933 n.33 (5th Cir. 2000), *overruled in part on other grounds*, *Equal Access for El Paso, Inc. v.*

(Continued on following page)

sought thereby to characterize its approach as somewhere within the judicial mainstream. But, as DHCS demonstrated in its petition for certiorari in *Independent Living*, the Ninth Circuit's approach was already an outlier, in terms of the scope and onerous nature of the atextual requirements that it imposed, *before* it issued this latest series of decisions. Those new decisions add yet more, increasingly detailed, requirements for a study that no federal statute or regulation requires. And no other Circuit has imposed duties directly on a state *legislature* under § 1396a(a)(30)(A). *See Minn. HomeCare*, 108 F.3d at 919 (Loken, J., concurring) ("Federal courts do not undertake administrative law review of legislative action, certainly not the action of a state legislature.").[14]

The Ninth Circuit's decisions in the present cases further underscore the need for this Court's intervention, whether in *Independent Living* or here. The decisions illustrate why preemption of state statutes

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Hawkins, 509 F.3d 697, 704 (5th Cir. 2007), *cert. denied*, 129 S. Ct. 34 (2008); *Methodist Hosps., Inc. v. Sullivan*, 91 F.3d 1026, 1030 (7th Cir. 1996); *Minn. HomeCare*, 108 F.3d at 918 *with Arkansas Med. Soc'y, Inc. v. Reynolds*, 6 F.3d 519, 531 (8th Cir. 1993).

[14] The Ninth Circuit's citation to *Minnesota HomeCare* also is ironic because the Eighth Circuit there affirmed summary judgment in the State's favor despite the fact that "DHS did not provide any formal analysis of the equal access factors to the legislature" in connection with the rate change at issue. 108 F.3d at 918.

based on conflicts with judicially created funding conditions that have no textual support in the preempting federal statute is completely unworkable, in addition to conflicting with this Court's discussion in *Pennhurst State School & Hospital v. Halderman*, 451 U.S. 1 (1981) regarding the nature of Spending Clause legislation. *Id.* at 17 ("[I]f Congress intends to impose a condition on the grant of federal moneys, it must do so unambiguously."). By adopting inconsistent, ever-expanding, ever-more-detailed rules, the Ninth Circuit has made it virtually impossible for California to enact a statute that directly (or at best, indirectly) may reduce reimbursements to Medicaid providers.

To recap the relevant history, the first decision in the series, *Orthopaedic*, required the State to "rely on responsible cost studies, its own or others," in setting rates, but did not require any study to be completed pre-implementation; rather, the State was permitted to implement the rate reductions while its cost analysis was underway. *See* 103 F.3d at 1494. To comply with *Orthopaedic*, in *Independent Living*, DHCS submitted declarations that analyzed the impact of the rate reductions on the § 1396a(a)(30)(A) factors, and on providers' costs, including cost data where it was available. But this was held insufficient because the Ninth Circuit held in *Independent Living II* that any studies must occur "before implementing [any] cuts," 572 F.3d at 648, and suggested, in a footnote, that they must be prepared "in anticipation" of the rate reduction. *Id.* at 652 n.9.

At the time that the cases at issue here were briefed in the district court, *Independent Living II* had not yet been decided. But the State was aware of the *Orthopaedic* decision, and also knew, based on the district court's willingness to enter an injunction in *Independent Living*, that relying on post-implementation declarations probably would not suffice to support AB1183 and SB6. To comply with then-existing Ninth Circuit precedent, therefore, in opposing the injunctions, the State produced a variety of material to the district courts, including formal reports discussing the specific reductions in light of the § 1396a(a)(30)(A) factors, and materials available to the Legislature when it deliberated. It is fairly indisputable that these materials would have sufficed under *Orthopaedic* – or, if not, at least the State would have been permitted to conduct additional analysis while the reductions remained in place.

However, none of this was enough under the new, expanded parameters announced by the Ninth Circuit in the present cases. When DHCS, as *the single state agency* designated under federal and state law to implement Medicaid in California, performed *pre-implementation* formal studies analyzing the impact of the specific reductions on the § 1396a(a)(30)(A) factors, the court rejected such studies as untimely and because the wrong entity conducted them. When the State produced evidence that the *Legislature* considered a *pre-enactment* analysis of pharmacies' costs (the Myers and Stauffer report), the court rejected that evidence because the proof that the

Legislature considered the report consisted of only "one-sentence" in a budget committee agenda. When the State produced evidence of *pre-enactment* analyses *prepared specifically for the Legislature* (the IHSS report prepared by DSS, and the LAO report recommending reduction of hospital reimbursements), the court found there was insufficient evidence that the Legislature actually considered them, and also held the analyses inadequate because they did not specifically mention either the preempting statute (§ 1396a(a)(30)(A)) or the state reduction (AB1183, SB6).

This is not what Congress intended. A state cannot run a $40 billion Medicaid program where every decision is potentially subject to private enforcement through court-imposed injunctions. To the contrary, Congress envisioned a program of cooperative federalism, under which the States are in constant communication with a federal agency, CMS, to receive guidance and to ensure compliance with federal law. However, the Ninth Circuit has taken for itself, and the federal courts, effective oversight of at least the provider reimbursements portion of the Medicaid program, and in so doing, has subjected the States to inconsistent and atextual requirements, with the consequence of hundreds of millions of dollars in lost Medicaid efficiencies (and reductions in *other* Medicaid programs, such as optional services). This cannot be what Congress intended when it enacted the Medicaid Act, and more recently when it repealed the Boren Amendment in an effort to

underscore the need for State flexibility in administering Medicaid programs, without interference from private suits challenging the adequacy of provider reimbursements. *See Pa. Pharmacists Ass'n v. Houstoun*, 283 F.3d 531, 538-40 & n.15 (3d Cir. 2002); *Evergreen*, 235 F.3d at 919 n.12; *see also Sanchez v. Johnson*, 416 F.3d 1051, 1059-60 (9th Cir. 2005).

Finally, under the Ninth Circuit's ruling in *Dominguez*, these cases are no longer limited to challenges to state statutes that directly reduce Medicaid reimbursement rates to providers. Now, any state Medicaid reform effort may be enjoined on the theory that it may *potentially* impact provider payments. Thus, in *Dominguez*, SB6 was held preempted even though it did not reduce payments to IHSS providers, but merely changed a statutory cap according to which the State's contribution is calculated. The connection to Medicaid reimbursement rates is even more attenuated in *Putz v. Schwarzenegger*, a case filed in federal district court in California in January 2010: there, plaintiffs are invoking § 1396a(a)(30)(A) and the Supremacy Clause in an effort to challenge (and enjoin) a reduced appropriation to entities that provide purely administrative support in connection with the provision of IHSS services. *See* App., *infra*, 236. *But see National Ass'n of Chain Drug Stores v. Schwarzenegger*, No. CV 09-7097 CAS (MANx), ___ F. Supp. 2d ___, 2009 WL 5253371 (C.D. Cal. Dec. 22, 2009) (refusing to enter injunction where reduction in reimbursement rates to

pharmacies did not "result of any state law or policy mandating a change in reimbursement").

Petitioners believe that the earlier-filed *Independent Living* petition is a suitable vehicle for reaching the overarching issue of whether a state statute reducing Medicaid rates may be preempted based on judicially created funding criteria that lack any textual support whatsoever. The *Independent Living* decisions developed most of the framework for the Ninth Circuit's current analysis. However, if the Court would prefer to reach the issue with respect to reductions that are still in effect, or to reach the full panoply of requirements that the Ninth Circuit has now imposed, it should grant the present petition instead (and hold the *Independent Living* petition pending the disposition of this case).

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

Dated: March 23, 2010

Respectfully submitted,

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FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

CALIFORNIA PHARMACISTS ASSOCIATION; CALIFORNIA MEDICAL ASSOCIATION; CALIFORNIA DENTAL ASSOCIATION; CALIFORNIA HOSPITAL ASSOCIATION; CALIFORNIA ASSOCIATION FOR ADULT DAY SERVICES; MARIN APOTHECARY, INC., DBA Ross Valley Pharmacy; SOUTH SACRAMENTO PHARMACY; FARMACIA REMEDIOS, INC.; ACACIA ADULT DAY SERVICES; SHARP MEMORIAL HOSPITAL; GROSSMONT HOSPITAL CORPORATION; SHARP CHULA VISTA MEDICAL CENTER; SHARP CORONADO HOSPITAL AND HEALTHCARE CENTER; FEY GARCIA; CHARLES GALLAGHER,

Plaintiffs-Appellees,

v.

DAVID MAXWELL-JOLLY, Director of The California Department of Health Care Services,

Defendant-Appellant.

No. 09-55532

D.C. No. 2:09-cv-00722-CAS-MAN

OPINION

Appeal from the United States District Court
for the Central District of California
Christina A. Snyder, District Judge, Presiding

Argued and Submitted
January 19, 2010 – Pasadena, California

Filed March 3, 2010

Before: Stephen Reinhardt, William A. Fletcher and Milan D. Smith, Circuit Judges.

Opinion by Judge Milan D. Smith, Jr.

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OPINION

MILAN D. SMITH, JR., Circuit Judge:

We are once again asked to consider whether the California Department of Health Care Services (Department) Director, David Maxwell-Jolly (Director), should be enjoined from implementing state legislation reducing payments to certain medical service providers. In this latest set of appeals, Plaintiffs-Appellees (California Pharmacists), a group of adult

day health care centers (ADHCs), hospitals, pharmacies, and beneficiaries of the State's Medicaid program, Medi-Cal, challenge a five percent reduction in those payments.[1] We affirm, and hold that the district court did not abuse its discretion in granting California Pharmacists's motion for a preliminary injunction because the State failed to "stud[y] the impact of the [five] percent rate reduction on the statutory factors of efficiency, economy, quality, and access to care" prior to implementing the rate reductions. *Indep. Living Ctr. of S. Cal., Inc. v. Maxwell-Jolly*, 572 F.3d 644, 652 (9th Cir. 2009) (*Independent Living II*).

FACTUAL AND PROCEDURAL BACKGROUND

I. Medicaid and Medi-Cal

Under Title XIX of the Social Security Act (the Medicaid Act), 42 U.S.C. § 1396 *et seq.*, the federal government provides funds to participating states to "enabl[e] each State, as far as practicable . . . to furnish . . . medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical

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[1] Here we deal only with providers and beneficiaries of ADHCs. Mirroring the analysis of today's holdings, we address the challenges to AB 1183 with respect to pharmacy and hospital providers, as well as their beneficiaries, in two separate, concurrently filed memorandum dispositions.

services." 42 U.S.C. § 1396-1. "Medicaid is a cooperative federal-state program that directs federal funding to states to assist them in providing medical assistance to low-income individuals." *Katie A. ex rel. Ludin v. Los Angeles County*, 481 F.3d 1150, 1153-54 (9th Cir. 2007). As we have stated many times, it is the states that choose whether to participate in Medicaid. Should a state choose to participate in the Medicaid program, it must comply with federal Medicaid law. *Id.* California has chosen to participate in the program.

To receive federal funds, states must administer their programs in compliance with individual "State plans for medical assistance," which require approval by the federal Secretary of Health and Human Services. 42 U.S.C. § 1396-1. The State plan must "[s]pecify a single State agency established or designated to administer or supervise the administration of the plan." 42 C.F.R. § 431.10. The Defendant-Appellee's agency, the Department, "is the state agency responsible for the administration of California's version of Medicaid, the Medi-Cal program." *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491, 1493 (9th Cir. 1997) (*Orthopaedic II*).

The Medicaid Act provides detailed requirements for state plans. *See* 42 U.S.C. § 1396a(a)(1)-(73). One of those provisions is § 1396a(a)(30)(A) (hereafter § 30(A)), the provision at issue in this appeal. Under § 30(A), a state plan must:

> provide such methods and procedures relating to . . . the payment for . . . care and services . . . as may be necessary . . . to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

Id. § 1396a(a)(30)(A). Thus, a state plan must establish health care provider reimbursement rates that are, among other things: (1) "consistent with high-quality medical care" (quality of care); and (2) "sufficient to enlist enough providers to ensure that medical services are generally available to Medicaid recipients" (access to care). *Indep. Living Ctr. of S. Cal., Inc. v. Shewry*, 543 F.3d 1050, 1053 (9th Cir. 2008) (*Independent Living I*).

II. Assembly Bill 5

On February 16, 2008, the California legislature enacted Assembly Bill X3 5 (AB 5) in special session. *See* 2008 Cal. Legis. Serv. 3rd Ex. Sess. Ch. 3. AB 5 reduced by ten percent payments under the Medi-Cal fee-for-service program for physicians, dentists, pharmacies, ADHCs, clinics, health systems, and other providers for services provided on or after July 1, 2008. Cal. Welf. & Inst. Code § 14105.19(b)(1). Section 14105.19 of the California Welfare & Institutions Code also reduced payments to managed health care

plans by the actuarial equivalent of the ten percent payment reduction. *Id.* § 14105.19(b)(3). Finally, AB 5 reduced payments to acute care hospitals not under contract with the Department for inpatient services. *Id.* § 14166.245(c). Under AB 5, these cuts were scheduled to take effect on July 1, 2008.

In *Independent Living II*, a group of pharmacies, health care providers, senior citizens' groups, and Medi-Cal beneficiaries brought an action under the Supremacy Clause, alleging that AB 5 conflicted with the requirements of § 30(A). We agreed, and held that under *Orthopaedic II* § 30(A) requires the Director to set provider reimbursement rates that "'bear a reasonable relationship to efficient and economical hospitals' costs of providing quality services, unless the Department shows some justification for rates that substantially deviate from such costs.'" *Indep. Living II*, 572 F.3d at 651 (quoting *Orthopaedic II*, 103 F.3d at 1496). We explained that *Orthopaedic II* interpreted § 30(A) to require the Director to "'rely on responsible cost studies, its own or others', that provide reliable data as a basis for its rate setting.'" *Id.* at 652 (quoting *Orthopaedic II*, 103 F.3d at 1496). However, prior to enacting AB 5,

> [t]he Director failed to provide any evidence that the Department or the legislature studied the impact of the ten percent rate reduction on the statutory factors of efficiency, economy, quality, and access to care . . . , nor did [the Director] demonstrate that the

> Department considered reliable cost studies when adjusting its reimbursement rates.

Id.

III. Assembly Bill 1183

On September 16, 2008, the California legislature passed Assembly Bill 1183 (AB 1183), which became effective on September 30, 2008. *See* Cal. Legis. Serv. Ch. 758. AB 1183 amended § 14105.19(b)(1) to provide that the ten percent rate reductions previously called for in AB 5 would end on February 28, 2009. *Id.* AB 1183 also added § 14105.191 and amended § 14166.245 of the California Welfare & Institutions Code, for either one percent, five percent, or ten percent rate reductions, depending on provider type. *See* Cal. Welf. & Inst. Code §§ 14105.191, 14166.245.

On January 29, 2009, California Pharmacists challenged the AB 1183 Medi-Cal reimbursement rate reductions. California Pharmacists sought to enjoin the Director from implementing AB 1183's five percent reduction in payments to ADHCs. ADHCs provide an alternative to institutional care, responding to the State's need "to establish and to continue a community-based system of quality adult day health care which will enable elderly persons or adults with disabilities to maintain maximum independence." Cal. Health & Safety Code § 1570.2. Though recognizing the need for custodial care, the California legislature has concluded that "overreliance on [custodial]

care has proven to be a costly panacea in both financial and human terms, often traumatic, and destructive of continuing family relationships and the capacity for independent living." *Id.*

The district court granted the preliminary injunction. It held that California Pharmacists had demonstrated a likelihood of success on the merits for three reasons. First, the legislative history showed no indication that the legislature considered § 30(A) prior to passage of AB 1183. Second, since the Department was given no discretion to alter the rate reductions imposed by the legislature, any analysis that the Department completed in February 2009, and thus after the reductions were enacted, did not satisfy the requirements of *Orthopaedic II*. And third, any analysis conducted by the Department was inadequate because the Department relied on costs incurred at intermediate care facilities (NF-As), which the district court considered to be an inadequate proxy for ADHC costs. The district court also held that California Pharmacists had demonstrated a risk of irreparable harm and that the balance of equities and public interest weighed in favor of injunctive relief. The Director timely appealed.

The Director raises three issues on appeal. First, the Director argues that the district court erred in holding that the legislature itself was required to conduct cost studies or analyses prior to enactment of AB 1183 to determine whether the proposed rate reductions complied with the efficiency, economy, and quality of care provisions of § 30(A). Second, the

Director contends that even if the legislature was required to conduct the relevant analysis, the district court committed clear error in concluding that the legislature did not adequately consider the § 30(A) factors prior to enacting AB 1183. Third, the Director argues that the district court erred in concluding that California Pharmacists had met their burden of demonstrating irreparable harm with respect to reduced reimbursement rates under AB 1183.

JURISDICTION AND STANDARD OF REVIEW

We have jurisdiction over this appeal pursuant to 28 U.S.C. § 1292(a)(1). A district court's decision to grant or deny a preliminary injunction is reviewed for abuse of discretion. *Indep. Living II,* 572 F.3d at 651. We recently restated our two-part test used to determine whether a district court has abused its discretion. First, we "determine de novo whether the trial court identified the correct legal rule to apply to the relief requested." *United States v. Hinkson,* 585 F.3d 1247, 1262 (9th Cir. 2009) (en banc). If the trial court did not identify the correct legal rule, it abused its discretion. *Id.* at 1262. Second, we must determine if the district court's "application of the correct legal standard was (1) 'illogical,' (2) 'implausible,' or (3) without 'support in inferences that may be drawn from the facts in the record.'" *Id.* (quoting *Anderson v. City of Bessemer City,* 470 U.S. 564, 577 (1985)).

In granting a request for a preliminary injunction, a district court abuses its discretion if it "base[s]

its decision on an erroneous legal standard or clearly erroneous findings of fact." *Earth Island Inst. v. U.S. Forest Serv.*, 442 F.3d 1147, 1156 (9th Cir. 2006), *abrogated on other grounds by Winter v. Natural Res. Def. Council, Inc.*, 129 S. Ct. 365 (2008). We review conclusions of law de novo and findings of fact for clear error. *Id.* Under this standard, "[a]s long as the district court got the law right, it will not be reversed simply because the appellate court would have arrived at a different result if it had applied the law to the facts of the case." *Id.* (internal quotation marks omitted).

DISCUSSION

In seeking a preliminary injunction in a case in which the public interest is involved, a plaintiff must overcome four hurdles. Thus, California Pharmacists must show that: (1) they are likely to succeed on the merits; (2) they are likely to suffer irreparable harm in the absence of preliminary relief; (3) the balance of equities tips in their favor; and (4) an injunction is in the public interest. *Cal. Pharms. Ass'n v. Maxwell-Jolly*, 563 F.3d 847, 849 (9th Cir. 2009) (citing *Winter*, 129 S. Ct. at 376); *see also Am. Trucking Ass'ns, Inc. v. City of Los Angeles*, 559 F.3d 1046, 1052 (9th Cir. 2009).

I. Likelihood of Success on the Merits

In *Orthopaedic II*, we held that § 30(A) requires

> the Director [to] set hospital outpatient reimbursement rates that bear a reasonable

> relationship to efficient and economical hospitals' costs of providing quality services, unless the Department shows some justification for rates that substantially deviate from such costs. To do this, the Department must rely on responsible cost studies, its own or others', that provide reliable data as a basis for its rate setting.

103 F.3d at 1496.

We address the Director's arguments in turn.

A. The Body Responsible for Complying with § 30(A)

First, the Director argues that *Orthopaedic II* did not hold that rate setting must be based upon pre-enactment legislative studies undertaken and completed by the legislature itself prior to legislative action authorizing a state department to implement rate reductions. According to the Director, at issue in *Orthopaedic II* were statutorily mandated rate changes not unlike those set pursuant to AB 1183. However, despite those enactments, we focused solely on the Department's actions, rather than on the legislature's, and thus only the Department is required to consider the § 30(A) factors. We disagree.

In *Orthopaedic II, none* of the disputed rate-settings was actually *set* by the legislature. *See Orthopaedic Hosp. v. Kizer,* No. 90-4209, 1992 WL 345652 (C.D. Cal. Oct. 5, 1992) (*Orthopaedic I*). To the contrary, the legislative enactments granted the

Director broad discretion to set the applicable rates in the face of general governing criteria. *See, e.g., Orthopaedic I,* 1992 WL 345652, at *7 (describing that reimbursement rates for rural hospitals were to "be set at a level which will provide incentives for rural hospitals to focus on the provision of outpatient services and . . . reduce the financial losses incurred by the facilities"); *id.* at *8 (describing that for delivery services rates the Department "shall eliminate the Medi-Cal reimbursement differential for obstetrical services" by equalizing reimbursement for Caesarean and non-Cesarean section deliveries); *id.* at *9 (statute required the Department to amend the method for reimbursing disproportionate share hospitals for outpatient services, to which the "Department responded by developing a new payment methodology"). Since the Director set the challenged rates, *Orthopaedic II* addressed whether the Medicaid Act "requires the *Department* to consider the costs hospitals incur in delivering services *when setting* specific payment rates under [§ 30(A)]." 103 F.3d at 1496 (emphases added). Looking to the clear language in the statute, we noted that § 30(A) "provides that *payments* for services must be consistent with efficiency, economy, and quality of care, and that those *payments* must be sufficient to enlist enough providers to provide access to Medicaid recipients." *Id.* We reasoned that costs were an integral factor to be considered in the payment calculus, since "[t]he Department cannot know *that it is setting rates* that are consistent with [§ 30(A)'s relevant factors] without considering the costs of providing such services." *Id.* (emphasis

added). Thus, we held that "*payments* for hospital outpatient services must bear a reasonable relationship to the costs of providing quality of care incurred by efficiently and economically operated hospitals." *Id.*

Unlike the statutes at issue in *Orthopaedic II*, the State has taken a different approach to setting rates under AB 1183. Under AB 1183, the legislature mandated that the Director reduce provider payments by a fixed percentage. *See, e.g.*, Cal. Welf. & Inst. Code § 14105.191(b)(2) ("[P]ayments to the following classes of providers shall be reduced by 5 percent for Medi-Cal fee-for-service benefits[.]"). Thus, the Director is misguided in arguing that our focus on the Department in *Orthopaedic II* absolves the legislature of the same requirements when it sets rates. In other words, in *Orthopaedic II*, there was no question that the Department set reimbursement rates. Those rates provided payments for the medical service at issue under the State's plan – there, hospital outpatient services. We had no reason to focus on what the State legislature considered before rates were set since the legislature was one step removed from the regulations promulgated by the Department. As noted, the legislature merely outlined broad goals for the Department, a process separate and distinct from determining the *effect* of a specific rate reduction on the statutory factors of efficiency, economy, quality, and access to care. Yet if the legislature elects to bypass the Department, and set rates itself, it must

engage in the same principled analysis we required of the Director in *Orthopaedic II*.

Moreover, in *Orthopaedic I*, the Director made the inverse of the argument he asserts here. There, he argued that in enacting the governing statutes, the legislature considered the relevant § 30(A) factors, thus excusing the Department's need to do the same when it set rates based on the legislature's commands. *See Orthopaedic I*, 1992 WL 345652, at *7-11. The district court rejected this argument, holding first that the statutes did not "purport to establish any specific payment rates," *id.* at 7, and second that even if the legislature had considered the relevant factors, that did not "relieve the Department of the obligation to further consider [the relevant factors] in exercising what discretion it had in implementing the legislature's general mandate," *id.* at 9. In addition, the court noted, "nor is there adequate evidence in the record demonstrating that the *state legislature* at any time considered [the relevant factors] in connection with the equalization of rates." *Id.* The district court explained:

> In sum, *if* there was evidence *both* that (1) in setting the challenging rates, the Department had merely in rote fashion been implementing a precisely-crafted statutory enactment that did not permit the Department to exercise any significant discretion whatsoever, and further, that (2) the legislature in enacting the statute had expressly considered "efficiency, economy, and quality of care," the Court might agree that the

> Department need not have considered "efficiency, economy, and quality of care," at all. But there is convincing evidence of neither.

Id. Thus, we are not telling the State something new.

Indeed, we find no distinction between the method by which rates were set under either AB 1183 or AB 5. Under AB 5, the California legislature enacted a statutorily mandated across-the-board rate reduction. In holding that the Director violated § 30(A) when he implemented AB 5's rate reductions, we held "[t]he Director failed to provide any evidence that the Department *or the legislature* studied the impact of the ten percent rate reduction on the statutory factors . . . *prior to enacting* AB 5." *Indep. Living II*, 572 F.3d at 652 (emphases added). We noted several times our concern with the context in which the *legislation* was passed, and focused on what State officials failed to consider prior to enactment. *See id.* at 655-56 (holding that the State's decision to pass legislation reducing Medi-Cal reimbursement rates for purely budgetary concerns violated federal law); *id.* at 656 (concluding that the State's Legislative Analyst was the only "State official" to have "considered – let alone studied" the impact of the rate reduction on services provided to Medi-Cal beneficiaries); *id.* at n.12 ("Nothing in the record connects the decision to cut Medi-Cal reimbursement rates by ten percent across-the-board to a factfinding process initiated by state officials."). Such an approach is consistent with that of our sister circuits, where in the context of legislative, as opposed to agency, rate-setting, they too have

focused on ensuring that the legislative body had information before it so that it could properly consider efficiency, economy, quality of care, and access to services *before* enacting rates. *See Minn. Homecare Ass'n, Inc. v. Gomez*, 108 F.3d 917, 918 (8th Cir. 1997) (holding that although the agency did not provide any formal § 30(A) analysis to the legislature, lobbyists "actively participated in the . . . legislative session" such that the legislature adequately considered § 30(A) when it raised reimbursement rates); *cf. Ark. Med. Soc'y, Inc. v. Reynolds*, 6 F.3d 519, 530 (8th Cir. 1993) (refusing to consider evidence offered during agency hearings regarding the effect of rate cuts on accessibility because it "could only be confirmed by historical data accumulated after the cuts were made").[2]

In sum, we find nothing remarkable in holding that the final body responsible for setting Medicaid reimbursement rates must study the impact of the contemplated rate reduction on the statutory factors of efficiency, economy, quality of care, and access to

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[2] The Director's reliance on *Folden v. Wash. State Dep't of Soc. & Health Servs.*, 981 F.2d 1054 (9th Cir. 1992), is also misplaced. In *Folden*, the owners of fourteen nursing home care facilities challenged Washington state Medicaid payments under a now repealed section of the Medicaid Act known as the Boren Amendment. 981 F.2d at 1056. We have numerous times rejected the Director's attempt to "graft past judicial interpretation of the Boren Amendment onto this court's interpretation of § 30(A)." *Indep. Living II*, 572 F.3d at 654-56 & nn.11-12; *Alaska Dep't of Health and Soc. Servs. v. Ctrs. for Medicare and Medicaid Servs.*, 424 F.3d 931, 940-41 (9th Cir. 2005).

care *prior to* setting or adjusting payment rates. We emphasize that the State need not follow "any prescribed method of analyzing and considering [the § 30(A)] factors." *Minn. Homecare Ass'n*, 108 F.3d at 918; *Orthopaedic II*, 103 F.3d at 1498 (refusing to impose a "rigid formula" for the Department to follow). But as we stated in *Orthopaedic II*, "Congress intended payments to be flexible within a range; payments should be no higher than what is required to provide efficient and economical care, but still high enough to provide for quality care and to ensure access to services." 103 F.3d at 1497. The only way to ensure that Congress's intent is realized is for the State to study the impact of the contemplated rate change on the statutory factors *prior to* setting rates. Thus, in no way do we mean to suggest that the State is proscribed from setting or adjusting reimbursement rates. We simply reaffirm that if it does so, it must comply with federal law.

B. Legislative Consideration Prior to Setting Rates

Having determined that the State legislature was required to study the impact of the five percent rate reduction on the statutory factors of efficiency, economy, quality, and access to care prior to enacting AB 1183, we next consider whether it did so. The Director argues that even though the legislature was not required to do so, the district court committed clear error in concluding that the legislature did not

adequately consider the § 30(A) factors prior to implementing AB 1183.

In support of his argument, the Director submits the declaration of the Department's Deputy Director for Legislative and Governmental Affairs. The Deputy Director states that in May 2008, the Senate and Assembly proposals were released in public hearings held by the Senate and Assembly Budget Committees. According to the Deputy Director, Department employees "provid[ed] information, technical assistance, and responses to numerous inquiries to legislative staff members concerning the various 5% and 1% rate reductions that were included in AB 1183." The Director also references the May 30, 2008, agenda released by the Assembly Budget Subcommitee No. 1 on Health and Human Services. That agenda lists certain "items to be heard" including proposed actions to "Maintain Essential Health Care Services and Eligibility," such as "Restore 10% provider rate cut for physicians and other healthcare providers" and "Partially restore long-term care rate reductions enacted in AB 5 X 3 (reduce cut from 10% to 5%)." The only proposed action that includes a discussion relevant to ADHCs explains that individuals with developmental disabilities living in Intermediate Care Facilities are eligible for ADHC services, and that such clarification in a trailer bill is necessary so that the State's Department of Developmental Services will no longer have to "fund these ADHC services at 100 percent General Fund cost."

Next, the Director points to the California Senate Committee on Budget and Fiscal Review for May 30, 2008, which includes recommendations for modification of several rate reductions or elimination of services. With respect to ADHC services, one entry contains the same description of the proposed trailer bill needed to clarify that individuals with developmental disabilities in Intermediate Care Facilities are eligible for participation in the ADHC Program. The other entry relevant to ADHCs is a brief explanation of the Department's request for an increase in funds for ADHC services due to an increase in enrollees.

The Director also points to the June 11, 2008, Subcommittee 3 Health, Human Services, Labor, and Veterans Affairs Major Action Report. That Report notes certain of the Department's "Highlights for the Medi-Cal Program." The Deputy Director calls particular attention to the entry that indicates that the 2008-09 budget bill "Provided a partial restoration to the rates reimbursed under Medi-Cal by providing a 5 percent across-the-board restoration to the 10 percent reduction as proposed by the Governor and taken in Special Session through [AB 5]. In the Medi-Cal Program, this resulted in an increase of about $597 million ($302 million General Fund)." The Report also noted adoption of the ADHC proposals set forth above.

The Director further points to the Budget Conference Committee 2008 Action List dated July 9, 2008, which shows seven items that the Assembly

and Senate voted on, ultimately contained in AB 1183, such as "Partial Restoration of Medi-Cal Fee-For-Service Provider Payments" and "Partial Restoration of Medi-Cal Pharmacy Rate." The Director argues that this Action List illustrates "that the Assembly and Senate voted on the very Medi-Cal rate reduction language that was ultimately contained in AB 1183." The July 2008 Summary Overview Budget Conference Committee Report summarizes many of the rate reductions enacted as part of AB 1183. Finally, the Director refers to the State's Legislative Analyst Office's analysis of the 2008-09 Budget, which includes recommendations from the State's Legislative Analyst concerning the Governor's proposed reductions to provider reimbursement.

The district court explicitly mentioned the legislative history described above (with the exception of the Legislative Analyst Office's analysis), and determined that it does not show that there was consideration of the § 30(A) factors. We agree, since the legislative history nowhere mentions any of the § 30(A) factors, *see Orthopaedic I*, 1992 WL 345652, at *8 ("Tellingly – although not dispositively *the terms 'efficiency,' 'economy,' and 'equality* [sic] *of care' appear nowhere in these documents.*"), and is concerned solely with budgetary matters, *see Indep. Living II*, 572 F.3d at 659 ("State budgetary concerns cannot . . . be the conclusive factor in decisions regarding Medicaid." (internal quotation marks omitted)). Indeed, the legislative history contains no indication that, in adjusting rates under AB 1183, the State "'rel[ied] on

responsible cost studies, its own or others', that provide reliable data as a basis for its rate setting.'" *Id.* at 652 (quoting *Orthopaedic II*, 103 F.3d at 1496). The Legislative Analyst Office's analysis of the 2008-09 Budget appears to be the very same report we referenced in *Independent Living II*. *See id.* at 656. It discusses the Governor's proposal of a *ten percent* provider rate reduction, which the State's own Legislative Analyst recommended rejecting for all providers except hospitals because those rate reductions had "the potential to negatively impact the operation of the Medi-Cal Program and the services provided to beneficiaries by limiting access to providers and services." It is hardly clear error for the district court to have failed to mention a report conducted without regard to the specific rate reductions before it. Accordingly, we will not disrupt the district court's factual findings, as they are not clearly erroneous.

C. The Department's Analysis

The Director also argues that the district court erred in failing to consider the analysis conducted by the Department, completed after the law's enactment. In rejecting the Department's analysis, the district court held that AB 1183 did not provide the Department with any discretion, citing Cal. Welf. & Inst. Code § 14105.191(a), which provides that "[n]otwithstanding any other provision of law, in order to implement changes in the level of funding for health care services, the director *shall* reduce provider payments." (emphasis added). The district court reasoned

that since the Department was not given any authority to alter the rate reduction imposed by the legislature, the Department's *post hoc* analysis does not satisfy the requirements of *Orthopaedic II*. The district court went on to hold that even if a *post hoc* analysis was sufficient, the Department relied on an inadequate proxy for ADHC costs when it considered data for NF-As.

To satisfy § 30(A), any analysis of reimbursement rates on the statutory factors of efficiency, economy, quality, and access to care, must have the potential to influence the rate-setting process. *See Indep. Living II*, 572 F.3d at 652 n.9 (holding that the district court did not abuse its discretion in concluding that *post hoc* rationalizations of the disputed reimbursement rates do not satisfy the procedural requirements of *Orthopaedic II*); *see also Orthopaedic II*, 103 F.3d at 1499 ("[T]he Department must consider hospitals' costs *based on* reliable information *when setting* reimbursement rates. . . ." (emphases added)); *Ark. Med. Soc'y*, 6 F.3d at 530. Yet the Department's analysis of AB 1183 with respect to ADHCs was issued on February 24, 2009, more than five months *after* the legislature enacted AB 1183, but prior to the cuts' implementation. Therefore, for the Department's analysis to have the requisite potential effect, the Director would have to have discretion regarding implementation of the rates.

In his reply brief, and for the first time in this litigation, the Director argues that the Department's post-enactment study is sufficient because the

Department retained discretion under AB 1183 not to *implement* the reductions before March 1, 2009. Thus, the Director argues, the Department's February 24, 2009, analysis would still be meaningful because the Director had authority to affect rates by deciding not to implement them.[3] Although the Director has

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[3] The Director's argument that he has discretion regarding the rates is drawn from a footnote in the district court's analysis in *Orthopaedic I*. There, the Director argued that legislative consideration of the § 30(A) factors excused the Department from again having to consider § 30(A). In rejecting that argument, the district court noted that the relevant statutory enactments "gave the Department fairly wide discretion in implementing the basic changes outlined in the statute." *Orthopaedic I*, 1992 WL 345652, at *9. To buttress that conclusion, the district court pointed out that under the Medicaid Act, the "ultimate responsibility" for administration of a state's Medicaid program is entrusted to a "single state agency." *Id.* at n.14 (quoting 42 C.F.R. § 431.10). As a result, the district court concluded that under federal law, the state agency has the "final say in what payment rates to set, *notwithstanding a legislature's efforts to provide broad guidelines for the agency.*" *Id.* (emphasis added). The court found it particularly relevant that the California legislature directed the Department to "seek federal approval for this section, if necessary." *Id.* (citing California Senate Bill 2563) (internal quotation marks omitted). The court also noted that subsection (a) under the Medi-Cal enabling statute grants the Department "extremely broad authority" to "comply with legislative budgetary enactments" only to the extent that those enactments comply with federal law. *Id.*

As we have described, there are a number of notable differences between the legislative enactments at issue in *Orthopaedic I* and AB 1183, thus raising the question of whether, under AB 1183, the Director had the "final say in what payment rates to set." *Id.* However, because we reject the Director's argument for the reasons set forth below, we do not decide whether differences between AB 1183 and the legislative enactments at

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clearly waived this argument by failing to raise it in his opening brief, *see Indep. Towers of Wash. v. Washington*, 350 F.3d 925, 929 (9th Cir. 2003), we nevertheless consider and reject the Director's argument on the merits.

The Director argues that if the Department determined that the reduced payments for any services would not comply with the relevant § 30(A) factors, the Department retained the discretion[4] not to implement those reductions. As a result, the legislature made implementation of the rate reductions dependent on whether the Department determined that they complied with federal law.[5]

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issue in *Orthopaedic I* are dispositive of the Director's discretion in this case.

[4] At oral argument the Director conceded that he did not have authority to change the rates set by the legislature, but, he argued, he could exercise a veto power based on a determination that the rates did not comply with the statutory factors in § 30(A). We need not decide whether the type of discretion contemplated by § 14105(a) of the California Welfare & Institutions Code is different from that under § 14105.191(i). That is, that the Director may "limit the rates," or "adopt regulations setting rates" under § 14105(a) would seem to provide for a different type of discretion than deciding simply not to implement the rates as set. However, because we hold that the Director did not retain any discretion to act once rates had been set, we do not discuss the distinction, if any, between the discretion contemplated by § 14105(a) as opposed to § 14105.191(i).

[5] We need not decide whether a study completed after rates have been set complies with § 30(A) where the Department has discretion not to implement the rates. For purposes of our analysis only, we assume such a study would suffice, but do not

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The Director relies on § 14105.191(i), which states:

> The department shall promptly seek any necessary federal approvals for the implementation of this section. To the extent that federal financial participation is not available with respect to any payment that is reduced or limited pursuant to this section, the director may elect not to implement that reduction or limitation.

Cal. Welf. & Inst. Code § 14105.191(i). The Director also points to the Medi-Cal enabling statute, Cal. Welf. & Inst. Code § 14105(a):

> The director shall prescribe the policies to be followed in the administration of this chapter, may limit the rates of payment for health care services, and shall adopt any rules and regulations as are necessary for carrying out, but are not inconsistent with, the provisions thereof.

Subsection (a) goes on to provide:

> In order to implement expeditiously the budgeting decisions of the Legislature, the director shall, to the extent permitted by federal law, adopt regulations setting rates that reflect these budgeting decisions within one month after the enactment of the Budget Act and of any other appropriation that

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so hold because we find that the Director did not retain any discretion in this case.

> changes the level of funding for Medi-Cal services.

Cal. Welf. & Inst. Code § 14105(a).

The Director's is not the most natural reading of the statute. Section 14105.191(i) does not clearly invest the Director with the discretion not to implement the legislature's rate reductions. Rather, it first directs the Department to "seek any necessary federal approvals" to implement the rate reductions. Cal. Welf. & Inst. Code § 14105.191(i). Only then does it permit the Director not to implement any reduction "[t]o the extent that federal financial participation *is not available.*" *Id.* (emphasis added). Thus, the most natural reading would seem to be one of budgetary concern; if federal money is not available for any particular payment reduction, the Director may choose to save the State money by not implementing the reduction. Such a reading comports with the budgetary nature of AB 1183's legislative history. *See Ariz. State Bd. For Charter Sch. v. U.S. Dep't of Educ.*, 464 F.3d 1003, 1008 (9th Cir. 2006) ("When a natural reading of the statute[ ] leads to a rational, commonsense result, an alteration of meaning is not only unnecessary, but also extrajudicial.").

The Director asks that we read into the statutory text a process by which the Department could first analyze the impact of the five percent payment reduction on the § 30(A) factors and then elect to implement the reduction based on that analysis. However, regardless of whether any such process was

contemplated in the statute, the record clearly demonstrates that no process of the kind the Director envisions took place. First, on September 30, 2008, the Department submitted its State Plan Amendment, incorporating AB 1183's rate reductions. In its State Plan Amendment, the Department stated that it had "determined that payments will continue to comply with any upper spending limits contained in Part 447 that were adopted to implement the 'efficiency, economy, and quality of care' provision of [§ 30(A)]. Beneficiaries will continue to have access to covered services as required by Part 447." Yet the Department did not issue a § 30(A) analysis until February 24, 2009 and produced nothing that would indicate that it studied the impact of AB 1183 on efficiency, economy, quality, and access to care prior to September 30, 2008. The State Plan Amendment also does not mention the Department's discretion not to implement the rate reductions based on federal participation.

In addition, on February 13, 2009, the State published notice in the California Regulatory Notice Register that "Section 14105.191 of the [Welfare and Institutions] Code is reducing the payments that would otherwise be paid for [adult day health care services] under the current rate methodology from 10 percent to 5 percent for dates of service on or after March 1, 2009. The State's Notice further provided that the Department

> is mandated by state law to implement the above change in reimbursement. [The

> Department] has considered the impact of this reimbursement on providers and Medi-Cal beneficiaries. [The Department's] assessment is that reimbursement will continue to compensate a high percentage of costs incurred for these facility services and that Medi-Cal beneficiaries will continue to have access to these services consistent with [§ 30(A)].

As with the State Plan Amendment, the Notice predates any analysis issued by the Department, yet definitively announces payment reductions from ten to five percent. Moreover, the Notice states that the Department "is mandated" to implement the rates, further undermining the Director's reading of § 14105.191(i).

In sum, the Director's argument that he retained discretion not to implement AB 1183's rate reductions is not supported by the record. The Department's February 24 analysis issued well after decisions had been made to reduce payments by five percent, and nothing in the record indicates that the Department retained the discretion not to implement the rate reductions based on a § 30(A) analysis. To comply with § 30(A), the State must study the impact of the contemplated rate reduction on the statutory factors of efficiency, economy, quality, and access to care prior to legislative enactment or in a manner that allows meaningful consideration of such input prior to implementation. Here, the State did neither.

In addition, regardless of whether the Director retained the discretion to act in the manner he posits, we agree with the district court that the Department's analysis was insufficient. Reviewing for clear error, we hold that the district court did not abuse its discretion in finding that the Department's reliance on NF-A rather than ADHC data was inadequate. The Department looked to the average costs of only six NF-A facilities, with widely varied costs, as a proxy for the 313 ADHCs in the Medi-Cal program. In its ADHC analysis, completed in February 2009, the Department explained that it had "just begun the process of auditing the costs of ADHCs for purposes of establishing rates under the new costs based methodology that is scheduled to go into effect on August 1, 2010[,]" and therefore, "in order to assess how ADHC reimbursement compares to the costs that may be incurred by an ADHC in providing ADHC services to Medi-Cal recipients," it used as a proxy how Medi-Cal reimbursement compares to NF-A costs. The Director concedes that a prospective cost reimbursement methodology for ADHCs is "still more than one year away." In the meantime, nothing in the record indicates that the district court clearly erred in concluding that the Department's use of NF-A costs was an inadequate proxy for ADHC costs. *Cf. Orthopaedic II*, 103 F.3d at 1500 (holding that the Department violated § 30(A) when readopting reimbursement rates for *hospitals* 'costs by not considering *hospitals*' costs when reevaluating its rates). Accordingly, it was not an abuse of discretion for the district court to have rejected the Department's analysis.

II. Irreparable Harm

The Director also argues that the district court erred in holding that California Pharmacists demonstrated a likelihood of irreparable harm. After reviewing the evidence, the district court held that "the evidence submitted by plaintiffs indicate[s] that Medi-Cal beneficiaries are at risk of losing access to ADHC services due to the AB 1183 rate reduction." The Director argues that in determining whether California Pharmacists have shown a likelihood of irreparable harm, the district court was required to compare Medi-Cal beneficiaries' access to ADHC services to that of the general population's.

Once again, under § 30(A), each state's Medicaid plan must be

> sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

42 U.S.C. § 1396a(a)(30)(A). This is referred to as the "equal access to care provision," *Orthopaedic II*, 103 F.3d at 1498, and requires that a state plan establish reimbursement rates sufficient to enlist enough providers to ensure that medical services are generally available to Medicaid recipients, *id.* at 1497. The Director argues that the district court erred in failing to apply the equal access to care provision in the context of plaintiffs' claims of irreparable injury. In other words, the Director argues that there can be no

finding of irreparable harm where "care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." § 30(A). According to the Director, applying this standard here, the evidence before the district court established that ADHC services are not generally available to the general population and thus California Pharmacists made no showing of irreparable injury.

In *Independent Living II*, we discussed the distinction between § 30(A)'s procedural and substantive requirements. We considered the "potential difficulties inherent in assessing substantive compliance with the factors laid out in § 30(A)," which made more attractive, by comparison, the "process-oriented view of the statute espoused in *Orthopaedic* [*II*]." *Indep. Living II*, 572 F.3d at 657. While explaining that there is a difference between substantive and procedural compliance with § 30(A), *id.* at 656, we also explained their interdependence, since "it is fair to assume that a rate that is set arbitrarily, without reference to the Section 30(A) requirements, is unlikely to meet the equal access and quality requirements," *id.* at 657 (internal quotation marks omitted). We reaffirmed *Orthopaedic II's* requirement that states comply with the procedural components of § 30(A) by setting provider reimbursement rates only after consideration of the relevant statutory factors of efficiency, economy, quality, and access to care. *Id.*

The Director's approach to the irreparable harm analysis conflates § 30(A)'s procedural and substantive

requirements. We do not require plaintiffs to show the State has committed a substantive violation of § 30(A)'s access provision when they can show that the State did not comply with § 30(A)'s procedural components. In other words, showing a procedural violation of the statute – that is, the State's failure to consider the impact of the contemplated rate on the statutory factors set forth in § 30(A) – may demonstrate a likelihood of success on the merits that the setting of provider reimbursement rates conflicts with § 30(A). Determining whether plaintiffs have made a sufficient showing of irreparable harm is a separate inquiry, which does not turn on the State's substantive compliance with § 30(A). Rather, to show a risk of irreparable harm, plaintiffs may show either, as Medicaid beneficiaries, "that enforcement of a proposed rule 'may deny them needed medical care[,]' " *Indep. Living II*, 572 F.3d at 658 (quoting *Beltran v. Myers*, 677 F.2d 1317, 1322 (9th Cir. 1982)), or, as Medicaid providers, that they will lose considerable revenue through the reduction in payments that they will be unable to recover due to the State's Eleventh Amendment sovereign immunity, *Cal. Pharms. Ass'n*, 563 F.3d at 850-52.

Requiring a substantive violation of the equal access to care provision in order to meet the irreparable injury prong would also run afoul of our Supremacy Clause jurisprudence. In *California Pharmacists*, we held that in an action brought under the Supremacy Clause, a finding of irreparable harm does not turn on "whether the plaintiffs asserting the economic

injury were in any sense intended beneficiaries of the federal statute on which the Supremacy Clause cause of action was premised." *Id.* at 851. Because "[a] cause of action based on the Supremacy Clause obviates the need for reliance on third-party rights," private parties bringing a Supremacy Clause cause of action can "enforce the structural relationship between the federal and state governments so long as they ha[ve] Article III standing as, essentially, private enforcers of the Supremacy Clause." *Id.* Thus, as stated above, plaintiffs need only show harm to Medi-Cal service providers or their members in order to obtain injunctive relief. *Id.* at 850. The Director's more narrow approach would allow injunctive relief only where plaintiffs are able to show that Medi-Cal *beneficiaries* have worse access to care and services than that available to the general population.

Finally, we have stated that even if § 30(A) imposes a substantive requirement, a rate reduction might still conflict with the statute if *at least some* providers stop treating Medi-Cal beneficiaries. *Indep. Livi..g II,* 572 F.3d at 656-57. The Director concedes that here, the evidence indicates that at least some ADHC Medi-Cal providers would stop treating beneficiaries due to AB 1183. Thus, even if we were to require a substantive violation of the statute to support a finding of irreparable harm, we would find that violation here.

Therefore, we reject the Director's argument that there can be no finding of irreparable harm unless the plaintiffs show a substantive violation of § 30(A)'s

access to care provision. The Director makes no serious attempt to dispute the district court's factual finding that, in light of the evidence, "Medi-Cal beneficiaries are at risk of losing access to ADHC services due to the AB 1183 rate reduction." Upon our review of the evidence, we do not find the district court's conclusion to be clearly erroneous. Accordingly, the district court did not abuse its discretion in finding that California Pharmacists established sufficient irreparable harm to warrant a preliminary injunction.

III. Balance of Equities and the Public Interest

Finally, the Director argues that because of the State's deepening fiscal crisis, a preliminary injunction should not issue. The Director insists that the legislature be allowed to exercise "its considered judgment" in a manner that serves the best interests of both Medi-Cal recipients and the State as a whole, and that injunctions against payment reductions have forced the State to eliminate many optional Medi-Cal services. The district court recognized the State's interest in meeting its financial obligations but held that the State's financial woes were outweighed by the public's interest in access to health care, particularly because "nothing . . . prevents [the State] from imposing a rate reduction after . . . appropriately consider[ing] and appl[ying] the relevant factors."

"The public interest analysis for the issuance of a preliminary injunction requires us to consider

'whether there exists some critical public interest that would be injured by the grant of preliminary relief.'" *Indep. Living II*, 572 F.3d at 659 (quoting *Hybritech Inc. v. Abbott Labs.*, 849 F.2d 1446, 1458 (Fed. Cir. 1988)). We have held that "there is a robust public interest in safeguarding access to health care for those eligible for Medicaid, whom Congress has recognized as 'the most needy in the country.'" *Id.* (quoting *Schweiker v. Hogan*, 457 U.S. 569, 590 (1982)). We continue to recognize this important public interest in the context of social welfare cases. As the district court stated, the State is free to exercise its "considered judgment" and reduce Medi-Cal reimbursement rates. Yet it may not do so for purely budgetary reasons, *Ark. Med. Soc'y*, 6 F.3d at 531, nor may it do so in a manner that violates federal law, *Indep. Living II*, 572 F.3d at 659. Accordingly, we hold that the district court did not abuse its discretion in concluding that the balance of hardships and the public interest weighed in favor of enjoining implementation of the five percent rate reduction required by AB 1183.

CONCLUSION

We have now handed down multiple decisions instructing the State on § 30(A)'s procedural requirements. We trust that the State now understands that in order for it to comply with § 30(A)'s "requirement that payments for services must be consistent with efficiency, economy, and quality of care, and sufficient to ensure access," *Orthopaedic II*, 103 F.3d at 1500, it

must: (1) "rely on responsible cost studies, its own or others', that provide reliable data as a basis for its rate setting," *id.* at 1496; *and* (2) study the impact of the contemplated rate change(s) on the statutory factors *prior to* setting rates, or in a manner that allows those studies to have a meaningful impact on rates before they are finalized. Because the State did neither with respect to AB 1183, we affirm the district court's order granting California Pharmacists's motion for a preliminary injunction.

AFFIRMED.

NOT FOR PUBLICATION

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

CALIFORNIA PHARMACISTS ASSOCIATION; et al., Plaintiffs, and CALIFORNIA HOSPITAL ASSOCIATION; et al., Plaintiffs-Appellants, v. DAVID MAXWELL-JOLLY, Director of The California Department of Health Care Services, Defendant-Appellee.	No. 09-55365 D.C. No. 2:09-cv-00722-CAS-MAN MEMORANDUM* (Filed Mar. 3, 2010)

Appeal from the United States District Court
for the Central District of California
Christina A. Snyder, District Judge, Presiding

Argued and Submitted January 19, 2010
Pasadena, California

Before: REINHARDT, W. FLETCHER and M. SMITH, Circuit Judges.

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* This disposition is not appropriate for publication and is not precedent except as provided by 9th Cir. R. 36-3.

Plaintiffs-Appellants California Hospital Association et al. sought a preliminary injunction in the district court to enjoin AB 1183's five percent Medi-Cal reimbursement rate reduction as to certain types of hospital services.[1] As the facts and procedural history are familiar to the parties, we do not recite them here except as necessary to explain our decision. We reverse the district court's denial of a preliminary injunction.

While the district court held that Plaintiffs had shown a likelihood of success on the merits, it held that the evidence submitted by Plaintiffs did not demonstrate that "Medi-Cal *beneficiaries* will go without access to needed inpatient and outpatient services under the AB 1183 rate reductions." (emphasis addded [sic]).

The district court abused its discretion in light of our holding in *California Pharmacists Association v. Maxwell-Jolly*, 563 F.3d 847 (9th Cir. 2009) (*California Pharmacists I*). *In California Pharmacists I*, we held that in an action brought under the Supremacy Clause, a finding of irreparable harm does not turn on "whether the plaintiffs asserting the

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[1] AB 1183's reimbursement rates vary depending on four types of hospital services: (1) inpatient services; (2) outpatient services; (3) Distinct Part Nursing Facilities; and (4) subacute services. With respect to inpatient services, this appeal concerns reimbursement for *non-contract* inpatient hospital services. Reimbursement rates for inpatient services at hospitals that have contracted with the State are unaffected by AB 1183.

economic injury were in any sense intended beneficiaries of the federal statute on which the Supremacy Clause cause of action was premised." 563 F.3d at 851. Because "[a] cause of action based on the Supremacy Clause obviates the need for reliance on third-party rights," Plaintiffs "could enforce the structural relationship between the federal and state governments so long as they had Article III standing as, essentially, private enforcers of the Supremacy Clause." *Id.* We went on to hold that the reduction in Medi-Cal revenue mandated by AB 1183 harmed Plaintiffs, *id.*, and that any such harm was irreparable because Plaintiffs could not recover money damages against the Department due to the State's Eleventh Amendment sovereign immunity, *id.* at 852.

We recently reaffirmed that holding. *Cal. Pharms. Ass'n v. Maxwell-Jolly*, No. 09-55532, slip op. at 3358-59 (9th Cir. Mar. 5, 2010) (*California Pharmacists II*). Here, Plaintiffs provided evidence of financial loss under each of the four categories of hospital services. With regard to inpatient services, Plaintiffs submitted evidence that no non-contract hospital would receive more than 90 percent of costs, while one-third of hospitals would receive less than 55 percent of their costs. Prior to AB 5 and AB 1183, 87 of the 95 affected hospitals were reimbursed between 95 and 100 percent for inpatient services. As to Distinct Part Nursing Facilities, prior to AB 5 and AB 1183, 84 percent of costs were reimbursed, whereas only 79 percent would be reimbursed under AB 1183, and many facilities would receive less than half of their

costs. Reimbursement for costs of subacute services would decrease from 98 to 93 percent for non-ventilator service providers and from 95 to 91 percent for ventilator service providers. And for outpatient services, reimbursement would decrease from 43 to 41 percent. Thus, Plaintiffs submitted substantial evidence demonstrating providers' financial loss under each of the four categories of hospital services. Such harm is to be considered irreparable in light of the State's Eleventh Amendment sovereign immunity. *California Pharmacists I*, 563 F.3d at 852. Accordingly, the district court abused its discretion in holding that the evidence submitted by Plaintiffs did not demonstrate a likelihood of irreparable harm.

We affirm the district court's holding as to Plaintiffs' likelihood of success on the merits for the reasons discussed in *California Pharmacists II*, slip op. at 33341-56.

We note that while the district court did not reach the issues of the balance of hardships and public interest with respect to Plaintiffs, it held in the related case dealing with adult-day health care centers that both factors weighed in favor of injunctive relief. We agree, and for the reasons set forth in *California Pharmacists II*, slip op. at 3360, hold that a preliminary injunction would be in the public interest. *See also California Pharmacists I*, 563 F.3d at 852-53.

For these reasons and those we provided in *California Pharmacists II*, slip op. at 3331-61, we

reverse the district court's denial of a preliminary injunction, and remand for it to enjoin AB 1183's five percent Medi-Cal reimbursement rate reduction as to the hospital services detailed *supra*.

REVERSED and REMANDED.

FOR PUBLICATION

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

CALIFORNIA PHARMACISTS ASSOCIATION, et al., Plaintiffs-Appellants, v. DAVID MAXWELL-JOLLY, Director of the Department of Health Care Services, State of California, Defendant-Appellee.	No. 09-55365 D.C. No. 2:09-cv-722-CAS-MAN Central District of California, Los Angeles ORDER (Filed Apr. 6, 2009)

Before: REINHARDT, BERZON, and M. SMITH, Circuit Judges.

Plaintiffs-Appellants, the California Pharmacists Association, et al., filed this suit to challenge the Medi-Cal reimbursement rate reductions to various providers as set forth in AB 1183. A group of the plaintiffs, the Hospital Plaintiffs, which comprises the California Hospital Association and some individual hospitals, filed a motion in the district court for a preliminary injunction to enjoin the defendant from reducing Medi-Cal fee-for-service rates to hospitals,[1] arguing that AB 1183 was enacted in

[1] Specifically, the Hospital Plaintiffs sought to enjoin the rate reductions as to four types of services: (1) inpatient services

(Continued on following page)

violation of § 1396a(a)(30)(A) of Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.* ((a)(30)(A)). The district court denied the preliminary injunction. The Hospital Plaintiffs filed an Emergency Motion Pursuant to Circuit Rule 27-3 for Preliminary Injunction Pending Appeal.

We review the denial of a preliminary injunction for abuse of discretion. *Earth Island Inst. v. U.S. Forest Serv.*, 442 F.3d 1147, 1156 (9th Cir. 2006). A district court abuses its discretion in denying a request for a preliminary injunction if it "base[s] its decision on an erroneous legal standard or clearly erroneous findings of fact." *Id.* (citation omitted). It also does so if in reaching its decision it makes a material error of law. We review conclusions of law de novo and findings of fact for clear error. *Id.*

Plaintiffs seeking a preliminary injunction in a case in which the public interest is involved must establish that they are likely to succeed on the merits, that they are likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in their favor, and that an injunction is in the public interest. *Winter v. Natural Res. Def. Council, Inc.*, 129 S. Ct. 365, 376 (2008). When deciding whether to issue a stay, including a stay of a state action that the district court has declined to enjoin, we consider: (1) whether the stay applicant

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for non-contract hospitals, (2) outpatient services, (3) Distinct Part Nursing Facilities, and (4) subacute services.

has made a strong showing that he is likely to succeed on the merits; (2) whether the applicant will be irreparably injured absent a stay; (3) whether issuance of the stay will substantially injure the other parties interested in the proceeding; and (4) where the public interest lies. *See Humane Soc'y of U.S. v. Gutierrez,* 527 F.3d 788, 789-90 (9th Cir. 2008).

In this case, the district court found that the Hospital Plaintiffs were likely to succeed on the merits, but that they failed to demonstrate irreparable harm. We address these issues in turn, and, in view of the time-urgency and the irreparability of the harm, also consider the other *Winter* factors which necessarily follow.

I. Likelihood of Success on the Merits

In *Orthopaedic Hospital v. Belshe,* 103 F.3d 1491 (9th Cir. 1997), we held that 42 U.S.C. § 1396a(a)(30)(A) requires the state to consider efficiency, economy, quality of care, and access before setting Medi-Cal reimbursement rates. *Id.* at 1496. The district court concluded that the Hospital Plaintiffs have shown a likelihood of success on the merits under *Orthopaedic* because the Legislature did not consider any such factors before passing the rate cuts in AB 1183. The court ruled that although the Department of Health Care Services (the Department) had performed some studies after AB 1183's passage, those post-hoc studies failed to meet the requirements of *Orthopaedic,* 103 F.3d at 1496. It noted that AB 1183 gives the

Department no discretion to alter the rate cuts based on the Department's own analysis, and, therefore, the cuts were not "based on" the Department's consideration of the relevant factors, but instead constituted a post-hoc rationalization for a legislative decision that had already been made. Op. at 9-11. Moreover, the district court determined that, although the state Legislative Analyst Office issued a report analyzing the proposed cuts, there was no evidence the legislature actually considered the report before enacting AB 1183. *Id.* at 10 n.8.

We conclude that the district court did not abuse its discretion in concluding that the Hospital Plaintiffs demonstrated a likelihood of success on the merits. Indeed, the Hospital Plaintiffs made a strong showing of such likelihood.

II. Irreparable Harm

The Hospital Plaintiffs must also show a likelihood of irreparable harm. *See Winter,* 129 S.Ct. at 375.

A. Harm

We first address the type of harm we may consider in the irreparable harm analysis. The Department argues that only harm to Medi-Cal beneficiaries is relevant to this motion, while the Hospital Plaintiffs assert that harm to Medi-Cal service providers is also relevant, and that they need show only the latter

type of harm, in this case harm to themselves or their members, in order to obtain injunctive relief. The Hospital Plaintiffs further claim that they or their members will lose considerable revenue between the effective date of AB 1183 and the date their claims can be reviewed on the merits if injunctive relief is denied.

We agree with the Hospital Plaintiffs. In *Independent Living Center v. Shewry* (*ILC*), we held that "a plaintiff seeking injunctive relief under the Supremacy Clause on the basis of federal preemption need not assert a federally created 'right,' in the sense that term has recently been used in suits brought under § 1983, but need only satisfy traditional standing requirements." 543 F.3d 1050, 1058 (9th Cir. 2008). We rejected the contention that federal statutes enacted pursuant to Congress's spending power, such as the one here at issue, are excluded from this principle, *id.* at 1059-62, and concluded that the health care providers in that case (which at that point did not include hospitals) had standing because:

> [A]ccording to their complaint, [they] will be "directly injured, by loss of gross income," when the ten-percent rate reduction takes effect. The Supreme Court "repeatedly has recognized that such [direct economic] injuries establish the threshold requirements" of Article III standing. . . . Moreover, this injury is directly traceable to the Director's implementation of AB 5 [the statute at issue in that case], and would certainly be redressed

> by a favorable decision of this court enjoining the ten-percent rate reduction.

Id. at 1065. Notably, *ILC* did *not* indicate that the service providers had standing to assert the interests of the beneficiary plaintiffs as third parties, as, for example, the medical service providers do in cases concerning the constitutional rights of patients. *See, e.g., Eisenstadt v. Baird,* 405 U.S. 438 (1972). A cause of action based on the Supremacy Clause obviates the need for reliance on third-party rights because the cause of action is one to enforce the proper constitutional structural relationship between the state and federal governments and therefore is not rights-based. In contrast, a case brought to enforce the Due Process or Equal Protection Clauses is rights based, and requires that the rights of *someone* be advanced, even if not the rights of the plaintiffs who have been injured.

Consistent with this understanding, in the various precedents cited throughout the *ILC* opinion in which plaintiffs brought cases directly under the Supremacy Clause, the interests asserted were basically economic, and there was no inquiry into whether the plaintiffs asserting the economic injury were in any sense intended beneficiaries of the federal statute on which the Supremacy Clause cause of action was premised. For example, in *Bud Antle, Inc. v. Barbosa,* one of the cases upon which we relied in *ILC,* we held that employers could sue to enjoin a California statute as preempted by the National Labor Relations Act (NLRA) "regardless of whether the NLRA conferred a

federal 'right' on employers." 45 F.3d 1261, 1271 n.13 (9th Cir. 1994). It was for that very reason that we concluded the § 1983 cases were inapposite, and that *Sanchez v. Johnson*, 416 F.3d 1051 (9th Cir. 2005), did not preclude the plaintiffs' suit. Essentially, the line of cases on which we relied held that private parties could enforce the structural relationship between the federal and state governments so long as they had Article III standing as, essentially, private enforcers of the Supremacy Clause; the specific relationship of those parties to the federal statute on which the Supremacy Clause cause of action is premised does not matter.

Given these underpinnings of *ILC*, there is little basis on which to import an "intended beneficiary" concept back into the case for purposes of determining irreparable injury. Applying this determination to the present motion, it is clear that AB 1183 harms the Hospital Plaintiffs and their members through reductions in Medi-Cal revenue payments.

B. Irreparability of Harm

Having determined that the Hospital Plaintiffs have shown unlawful harm under § (a)(30)(A), we next consider whether the harm is irreparable. Typically, monetary harm does not constitute irreparable harm. *L.A. Mem'l Coliseum Comm'n v. Nat'l Football League*, 634 F.2d 1197, 1202 (9th Cir. 1980). The Hospital Plaintiffs argue that in this case, however, the monetary injury is irreparable because the Eleventh

Amendment sovereign immunity of the Department (a branch of the State of California government) bars the Hospital Plaintiffs from ever recovering damages in federal court. The most relevant authority on this issue – though not controlling – supports the Hospital Plaintiffs' argument. *See Kan. Health Care Ass'n v. Kan. Dep't of Soc. & Rehab. Servs.*, 31 F.3d 1536, 1543 (10th Cir. 1994) ("Because the Eleventh Amendment bars a legal remedy in damages . . . the court held that plaintiffs' injury was irreparable. We agree."). We note also that Supreme Court case law and some of our own cases clarify that economic damages are not traditionally considered irreparable *because the injury can later be remedied by a damage award. See Sampson v. Murray*, 415 U.S. 61, 90 (1974) ("[I]t seems clear that the temporary loss of income, ultimately to be recovered, does not usually constitute irreparable injury. . . . The possibility that adequate compensatory or other corrective relief will be available at a later date, in the ordinary course of litigation, weighs heavily against a claim of irreparable harm." (internal quotation omitted)); *Rent-A-Center, Inc. v. Canyon Television & Appliance Rental, Inc.*, 944 F.2d 597, 603 ("It is true that economic injury alone does not support a finding of irreparable harm, *because such injury can be remedied by a damage award.*" (emphasis added)); *Caribbean Marine Servs. Co. v. Baldridge*, 844 F.2d 668, 676 (9th Cir. 1988); *Arcamuzi v. Cont'l Air Lines, Inc.*, 819 F.2d 935, 938 (9th Cir. 1987); *Colo. River Indian Tribes v. Town of Parker*, 776 F.2d 846, 850-51 (9th Cir. 1985); *Goldie's Bookstore, Inc. v. Superior Court*, 739 F.2d 466, 471

(9th Cir. 1984) ("Mere financial injury . . . will not constitute irreparable harm *if adequate compensatory relief will be available in the course of litigation.*" (emphasis added)).

Because the economic injury doctrine rests only on ordinary equity principles precluding injunctive relief where a remedy at law is adequate, it does not apply where, as here, the Hospital Plaintiffs can obtain no remedy in damages against the state because of the Eleventh Amendment. *See Kan. Health Care Ass'n*, 31 F.3d at 1543.[2]

Considering the relevant authorities, we are persuaded that because the Hospital Plaintiffs and their members will be unable to recover damages against the Department even if they are successful on the merits of their case, they will suffer irreparable harm if the requested injunction is not granted.

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[2] We observe that, although damages may become available to the Hospital Plaintiffs in state court, persuasive authority suggests that federal courts may consider only what *federal* remedies are available. *See United States v. New York*, 708 F.2d 92, 93-94 (2d Cir. 1983) (per curiam) (holding that "federal courts may consider only the available *federal* legal remedies"). *But see Kan. Health Care Ass'n*, 31 F.3d at 1543 ("Because the Eleventh Amendment bars a legal remedy in damages, *and the court concluded no adequate state administrative remedy existed*, the court held that plaintiffs' injury was irreparable. We agree." (emphasis added)). We find the reasoning of *New York* to be more persuasive, and consider *only* prospective federal remedies for the purpose of gauging whether the harm caused to the Hospital Plaintiffs and their members is irreparable.

III. Equities and the Public Interest

The district court did not reach the question of the equities and the public interest. Although the state argues that these factors weigh in its favor because an injunction will worsen the state's budget crisis, the record reflects that the impact of a stay on the budget crisis will be minimal at most. Further, it is clear that it would not be equitable or in the public's interest to allow the state to continue to violate the requirements of federal law, especially when there are no adequate remedies available to compensate the Hospital Plaintiffs for the irreparable harm that would be caused by the continuing violation. In such circumstances, the interest of preserving the Supremacy Clause is paramount. *See Am. Trucking Ass'n v. City of Los Angeles*, ___ F.3d ___, 2009 WL 723993, at *12 (9th Cir. Mar. 20, 2009) (considering the public interest represented by "the Constitution's declaration that federal law is to be supreme").

In light of the showing made by the Hospital Plaintiffs in this case, we grant their motion for an order staying the rate cuts in AB 1183 with respect to the specified hospital services pending their appeal to this court of the district court's order denying the motion for preliminary injunction.

MOTION FOR STAY PENDING APPEAL IS GRANTED.

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

CALIFORNIA PHARMACISTS ASSOCIATION, et al., Plaintiffs-Appellants, v. DAVID MAXWELL-JOLLY, Director of the Department of Health Care Services, State of California, Defendant-Appellee.	No. 09-55365 D.C. No. 2:09-cv-722-CAS-MAN Central District of California, Los Angeles ORDER (Filed Aug. 24, 2009)

Before: REINHARDT, W. FLETCHER, and M. SMITH, Circuit Judges.

The panel has unanimously voted to deny the petition for rehearing en banc. The full court has been advised of the petition for rehearing en banc and no judge of the court has requested a vote on it. Fed. R. App. P. 35.

The petition for rehearing en banc is DENIED.

NOT FOR PUBLICATION

UNITED STATES COURT OF APPEALS

FOR THE NINTH CIRCUIT

INDEPENDENT LIVING CENTER OF SOUTHERN CALIFORNIA, INC.; et al., Plaintiffs-Appellees, v. DAVID MAXWELL-JOLLY, Director of Department of Health Care Services of the State of California, Defendant-Appellant.	No. 09-55692 D.C. No. 2:09-cv-00382-CAS-MAN MEMORANDUM* (Filed Mar. 3, 2010)

Appeal from the United States District Court
for the Central District of California
Christina A. Snyder, District Judge, Presiding.

Argued and Submitted Jan. 19, 2010.
Pasadena, California

Before: REINHARDT, W. FLETCHER and M. SMITH, Circuit Judges.

Plaintiffs-Appellees Independent Living Center of Southern California, Inc., et al. sought a preliminary injunction in the district court to enjoin

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* This disposition is not appropriate for publication and is not precedent except as provided by 9th Cir. R. 36-3.

AB 1183's five percent Medi-Cal reimbursement rate reduction as to providers of pharmacy services. As the facts and procedural history are familiar to the parties, we do not recite them here except as necessary to explain our decision. We affirm the district court's grant of the preliminary injunction.

For the reasons discussed in *Cal. Pharms. Ass'n v. Maxwell-Jolly*, No. 09-55532, slip op. at 3331-3361 (9th Cir. Mar. 3, 2010) (*California Pharmacists II*), we reject the Director's contention that the State legislature was not required to study the impact of the five percent rate reduction on the statutory factors of efficiency, economy, quality, and access to care, prior to enacting AB 1183.

The primary issue in this appeal is whether the legislature actually conducted the requisite analysis prior to enacting AB 1183. At oral argument, the Director called our attention to a December 2007 Survey of Dispensing and Acquisition Costs of Pharmaceuticals in the State of California, which was prepared for the Department by the accounting firm Myers and Stauffer LC (the Myers and Stauffer Study). The Director referenced the Myers and Stauffer Study in its briefing before the district court, but only to support the argument that the *Department* had sufficiently considered the § 30(A) factors prior to *implementing* the five percent rate reduction. However, for the reasons we explained in *California Pharmacists* II, slip op. at 3349-3355, any analysis performed by the Department was inadequate because the Department did not retain the discretion

not to implement the rate reductions based on a § 30(A) analysis.

On appeal, the Director argues that the *legislature* also considered the Myers and Stauffer Study, because it appears in the "Comments" column of the May 30, 2008 agenda released by the Assembly Budget Subcommitee No. 1 on Health and Human Services. That comment reads: "Dec. 2007 Myers and Stauffer study found that current Medi-Cal drug pricing averages around 5 percent over cost." The Director did not argue in his briefing, either here or in the district court, that the citation to the Myers and Stauffer Study in the May 2008 agenda satisfied § 30(A)'s requirements. However, the Director presented the agenda to the district court as part of AB 1183's legislative history, and the district court held that the legislative history shows no indication that the § 30(A) factors were considered. We have held that the district court's finding on that issue was not clearly erroneous. *See California Pharmacists II*, slip op. at 3349.

In any event, for two additional reasons, we reject the Director's reliance on the Myers and Stauffer Study to satisfy the requirement that the *legislature* "stud[ied] the impact of the contemplated rate change(s) on the statutory factors prior to setting rates, or in a manner that allow[ed] those studies to have a meaningful impact on rates before they [were] finalized." *California Pharmacists II*, slip op. at 3360-61 (emphasis omitted). First, the one-sentence citation to the May 30, 2008 agenda does not show

adequate consideration of the § 30(A) factors. Second, while the Myers and Stauffer Study provides a detailed discussion of costs, it is bereft of any analysis of the remaining § 30(A) factors – efficiency, economy, quality, and access to care. *See California Pharmacists II*, slip op. at 3360 (holding that the State must consider costs *and* study the impact of the rate change on the statutory factors). Indeed, the Myers and Stauffer Study notes several times that it is only a cost study, and recommends that the Department conduct additional analysis in light of those costs. *See, e.g.*, Myers and Stauffer Study at 79 ("There are several factors that should be considered in determining an appropriate pharmacy reimbursement formula for Medi-Cal. These factors include dispensing costs . . . , drug acquisition costs and market dynamics . . . balanced with the need to maintain sufficient access to services for Medi-Cal recipients throughout the state."); *id.* ("Myers and Stauffer recommends that the Department of Health Services evaluate its pharmacy participation level as well as any additional data sources available for tracking complaints about recipient access to services."); *id.* at 81 ("The cost survey performed by Myers and Stauffer reports aggregate historical costs of dispensing as observed in the current provider community but does not determine if the costs observed are reflective of providers operating in the most efficient manner possible."); *id.* ("An evaluation of the dispensing fee should also consider issues of access to services, reimbursement rates prevalent in the marketplace from other third party payers and payment rates that

promote incentives for provider efficiency."). Accordingly, we affirm the district court's holding concerning Plaintiffs' likelihood of success on the merits because the State did not study the impact of the five percent rate reduction on the statutory factors prior to enacting AB 1183, or in a manner that allowed those studies to have a meaningful impact on rates before they were finalized. *See California Pharmacists II*, slip op. at 3360-61.

Nor did the district court abuse its discretion in finding that Plaintiffs demonstrated irreparable harm. After considering both parties' evidence, the district court concluded that the Director failed to refute Plaintiffs' showing of irreparable harm. The district court concluded that even if, on average, pharmacies would be compensated above their acquisition costs, the Director had not refuted Plaintiffs' showing that many brand and generic drugs would be reimbursed at a level below cost, limiting Medi-Cal patients' access to those drugs. The district court noted that because many single-source drugs are protected from competition by patents, there are no available generic alternatives. The court also concluded that if pharmacies are forced to curtail services or go out of business, existing customers would not have access to other pharmacies, especially since home-delivery services would end. It further noted that independent pharmacies represent thirty-three percent of the licensed community pharmacies in California and that they would be severely impacted by the reductions.

Contrary to the Director's argument, the district court did not disregard the Director's evidence, and the Director cannot rely solely on asking this court to reweigh the evidence presented to the district court. *Indep. Living Ctr. of S. Cal., Inc. v. Maxwell-Jolly*, 572 F.3d 644, 658 (9th Cir. 2009). The district court's conclusion that Plaintiffs would suffer irreparable harm was not clear error.

The district court also did not abuse its discretion in determining that the balance of hardships tipped decidedly in Plaintiffs' favor. *See California Pharmacists II*, slip op. at 3360.

For these reasons and those we provided in *California Pharmacists II*, slip op. at 3331-61, we affirm the district court's grant of a preliminary injunction. **AFFIRMED.**

FOR PUBLICATION

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

LYDIA DOMINGUEZ, by and through her mother and next friend Lisa Brown; ALEX BROWN, by and through his mother and next friend Lisa Brown; DONNA BROWN, by and through her conservator and next friend Julie Weissman-Steinbaugh; CHLOE LIPTON, by and through her conservator and next friend Julie Weissman-Steinbaugh; HERBERT M. MEYER, on behalf of themselves and a class of those similarly situated; LESLIE GORDON, on behalf of themselves and a class of those similarly situated; CHARLENE AYERS, on behalf of themselves and a class of those similarly situated; WILLIE BEATRICE SHEPPARD, on behalf of themselves and a class of those similarly situated; ANDY MARTINEZ, on behalf of themselves and a class of those similarly situated; SERVICE EMPLOYEES INTERNATIONAL UNION UNITED HEALTH CARE WORKERS WEST; SERVICE EMPLOYEES INTERNATIONAL UNION UNITED LONG-TERM CARE WORKERS; SERVICE EMPLOYEES INTERNATIONAL UNION LOCAL 521;

No. 09-16359

D.C. No.
4:09-cv-02306-CW

OPINION

SERVICE EMPLOYEES INTERNATIONAL UNION CALIFORNIA STATE COUNCIL,

Plaintiffs-Appellees,

v.

ARNOLD SCHWARZENEGGER, Governor of the State of California; JOHN A. WAGNER, Director of the California Department of Social Services; DAVID MAXWELL-JOLLY, Director of the California Department of Health Care Services; JOHN CHIANG California State Controller,

Defendants-Appellants,

and

FRESNO COUNTY; FRESNO COUNTY IN-HOME SUPPORTIVE SERVICES PUBLIC AUTHORITY,

Defendants.

Appeal from the United States District Court
for the Northern District of California
Claudia Wilken, District Judge, Presiding

Argued and Submitted
January 19, 2010 – Pasadena, California

Filed March 3, 2010

Before: Stephen Reinhardt, William A. Fletcher and Milan D. Smith, Jr., Circuit Judges.

Opinion by Judge Milan D. Smith, Jr.

COUNSEL

Stephen P. Berzon, Scotta A. Kronland, Stacey M. Leyton, Peder J. Thoreen, and Anne N. Arkush of Altshuler Berzon LLP, San Francisco, California, for the plaintiffs-appellees.

Edmund G. Brown, Jr., Attorney General of California, Douglas N. Press, Senior Assistant Attorney General, Susan M. Carson, Supervising Deputy Attorney General, and Gregory D. Brown and Michael A. Zwibelman, Deputy Attorneys General, San Francisco, California, for the State defendants-appellants.

OPINION

MILAN D. SMITH, JR., Circuit Judge:

In 1973, the State of California established the In-Home Supportive Services (IHSS) program to provide in-home assistance and care to low-income elderly and disabled persons who otherwise would be unable to remain safely in their homes. *See* Cal. Welf. & Inst. Code § 12300. Plaintiffs-Appellees, a putative class comprised of recipients of the State's IHSS program and the unions who represent IHSS providers, seek to enjoin state legislation that reduces the state contribution to wages paid to IHSS providers because it is preempted by Section 30(A) of the Medicaid Act. The district court issued a preliminary injunction. We affirm.

FACTUAL AND PROCEDURAL BACKGROUND

Under Title XIX of the Social Security Act (the Medicaid Act), 42 U.S.C. § 1396 *et seq.*, the federal government grants states funds to use towards state-administered programs that provide medical assistance to low income individuals.[1] To receive federal funds, states must administer their programs in compliance with individual "State plans for medical assistance," which require approval by the federal Secretary of Health and Human Services. 42 U.S.C. § 1396-1. The California Department of Health Care Services (Department) is designated the "single State agency established or designated to administer or supervise the administration of the [State] plan." 42 C.F.R. § 431.10(b).

IHSS is one of the programs for which California receives federal funding under its version of Medicaid, known as Medi-Cal. Medi-Cal operates via a prospective reimbursement system, whereby the State "sets reimbursement rates for specific services, regardless of where those services are performed." *Orthopaedic*, 103 F.3d at 1493. IHSS recipients

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[1] For a more detailed discussion of the Medicaid Act, we refer the reader to our prior decisions. *See, e.g., Cal. Pharm. Ass'n v. Maxwell-Jolly*, slip op. at 3331-61 (9th Cir. March 3, 2010) (*California Pharmacists II*); *Indep. Living Ctr. of S. Cal., Inc. v. Maxwell-Jolly*, 572 F.3d 644 (9th Cir. 2009) (*Independent Living II*); *Indep. Living Ctr. of S. Cal., Inc. v. Shewry*, 543 F.3d 1050 (9th Cir. 2008) (*Independent Living I*); *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491 (9th Cir. 1997).

receive a host of "supportive services . . . [,] which make it possible for the recipient to establish and maintain an independent living arrangement." Cal. Welf. & Inst. Code § 12300(b). These services, which are provided in the beneficiary's home, include assistance with ambulation, bathing, oral hygiene, grooming, dressing, bowel and bladder care, feeding, and self-administration of medications. *Id.* § 12300(b)-(d). There are over 360,000 IHSS providers serving 440,000 individuals in California; sixty-two percent of IHSS recipients receive care from an IHSS provider who is also a relative. In many cases, supportive services are provided by a parent, who is eligible to receive payment for caring for his or her child only upon leaving full-time employment or if the parent is unable to obtain full-time employment because no other suitable provider is available and the child would be left with inadequate care. *See* Cal. Welf. & Inst. Code § 12300(e).

The IHSS program is paid for and administered through a combination of federal, state, and county funds. The State has authorized counties to provide for the delivery of IHSS services by one of two methods: first, a county may hire IHSS providers directly; or second, a county may contract with a nonprofit consortium (NPC) or establish a public authority (PA) – an entity separate from the county that performs public and essential governmental functions necessary to deliver IHSS services. *See* Cal. Welf. & Inst. Code §§ 12302, 12301.6(a)-(b). Fifty-six of the State's fifty-eight counties have established a NPC or PA.

NPCs and PAs are considered employers of IHSS providers for purposes of collective bargaining over wages, hours, and other terms and conditions of employment, although IHSS recipients retain the right to hire, fire, and supervise the work of their individual IHSS provider. *Id.* § 12301.6(c).

In counties that have established a NPC or PA, wages and benefits are established through collective bargaining between the NPC or PA and the providers' union. Cal. Welf. & Inst. Code § 12301.6(c). Before any increase in wages or benefits may take effect, it must be approved by the Department, which determines whether the increase is consistent with federal law and ensures that federal financial participation is available. *Id.* § 12306.1(a).

For the IHSS program, the California legislature has directed the Department to establish a provider reimbursement rate methodology that: (1) is consistent with the functions and duties of NPCs and PAs; (2) "[m]akes any additional expenditure of state general funds subject to appropriation in the annual Budget Act"; and (3) "[p]ermits county-only funds to draw down federal financial participation consistent with federal law." *Id.* § 14132.95(j)(2)(A)(i)-(iii). In establishing its rate-setting methodology, the Department is also authorized to "[d]eem the market rate for like work in each county . . . to be the cap for increases in payment rates for individual practitioner services," and "[p]rovide for consideration of county input concerning the rate necessary to ensure access to services in that county." *Id.* § 14132.95(j)(2)(C).

Following the passage of the American Recovery and Reinvestment Act of 2009 (ARRA), the federal government contributes approximately sixty-two percent of the overall cost of the IHSS program.[2] Of the remaining "non-federal share," the State contributes sixty-five percent while the county contributes thirty-five percent. Cal. Welf. & Inst. Code § 12306(b). However, the State's contribution is subject to a statutory cap. Prior to implementation of the statute at issue in this case, California Welfare & Institutions Code § 12306.1(d)(6) (effective July 1, 2009), the State contributed sixty-five percent of the non-federal share up to $12.10 per hour. *Id.* § 12306.1(c)-(d). That statutory cap has increased over time, beginning at $8.10 per hour in 2000 and reaching $12.10 by way of four statutory increases. *See id.* § 12306.1(d)(1)-(5).

However, on February 20, 2009, the Governor signed § 12306.1(d)(6) into law. Scheduled to take effect July 1, 2009, § 12306.1(d)(6) reduces the statutory maximum for which the State would contribute its proportionate share for IHSS wages and benefits from $12.10 per hour to $10.10 per hour. In other words, the State's maximum contribution to wages and benefits would be reduced from sixty-five percent of the non-federal share of an hourly rate up to $12.10 to sixty-five percent of the non-federal share of an hourly rate up to $10.10.

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[2] Prior to enactment of the ARRA, the federal government contributed fifty percent of the program's costs.

The new law does not require counties to reduce wages and benefits paid to IHSS service providers. Counties are permitted to make up the difference between the State's current contribution and any reduction that may result from the State's decreased contribution. Currently, thirty-four of the fifty-six NPCs and PAs pay IHSS providers $10.10 per hour or less in wages and benefits, so there would be no reduction in the State's contribution in any of those counties, including Los Angeles County in which forty-two percent of all IHSS services are provided. Twenty-two counties are, however, directly affected by the rate change. According to Plaintiffs, in response to § 12306.1(d)(6), fourteen of those counties that were paying wages and benefits of more than $10.10 per hour have thus far submitted Rate Change Requests to the Department of Social Services (DSS), seeking to reduce wages effective July 1, 2009.[3] All of these Rate Change Requests were approved by DSS and the Department.

On May 26, 2009, Plaintiffs brought this action challenging § 12306.1(d)(6) under the Supremacy Clause, claiming that in enacting and implementing

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[3] On May 1, 2009, DSS issued All-County Information Notice No. I-34-09 notifying counties of § 12306.1(d)(6). The notice instructed: "Counties currently providing wages and individual health benefits above $10.10 must submit a PA Rate Change Request to reflect the change in the maximum amount in which the state will participate. A letter of intent to complete a Rate Change Request must be submitted to [DSS] by June 1, 2009 from each of the counties affected by the statutory change."

§ 12306.1(d)(6), the State failed to comply with the procedural and substantive requirements of 42 U.S.C. § 1396a(a)(30)(A) (hereafter § 30(A)).[4] After noting that the State conceded that the legislature did not consider the § 30(A) factors prior to adopting § 12306.1(d)(6), the district court granted the preliminary injunction. Defendants appealed.

JURISDICTION AND STANDARD OF REVIEW

We have jurisdiction over this appeal pursuant to 28 U.S.C. § 1292(a)(1). A district court's decision to grant or deny a preliminary injunction is reviewed for abuse of discretion. *Indep. Living II*, 572 F.3d at 651. Reviewing for abuse of discretion, first, we "determine de novo whether the trial court identified the correct legal rule to apply to the relief requested." *United States v. Hinkson*, 585 F.3d 1247, 1262 (9th Cir. 2009) (en banc). If the trial court did not identify the correct legal rule, it abused its discretion. *Id.* Second, we must determine if the district court's "application of the correct legal standard was (1) 'illogical,' (2) 'implausible,' or (3) without 'support in inferences that may be drawn from the facts in the record.'" *Id.* (quoting *Anderson v. City of Bessemer City*, 470 U.S. 564, 577 (1985)).

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[4] Plaintiffs also alleged unlawful discrimination under the Americans with Disabilities Act and Rehabilitation Act. The district court did not address Plaintiffs' ADA or Rehabilitation Act claims and they are not before us on appeal.

In granting a request for a preliminary injunction, a district court abuses its discretion if it "base[s] its decision on an erroneous legal standard or clearly erroneous findings of fact." *Earth Island Inst. v. U.S. Forest Serv.*, 442 F.3d 1147, 1156 (9th Cir. 2006), *abrogated on other grounds by Winter v. Natural Res. Def. Council, Inc.*, 129 S. Ct. 365 (2008). We review conclusions of law de novo and findings of fact for clear error. *Id.* Under this standard, "[a]s long as the district court got the law right, it will not be reversed simply because the appellate court would have arrived at a different result if it had applied the law to the facts of the case." *Id.* (internal quotation marks omitted).

DISCUSSION

In seeking a preliminary injunction in a case in which the public interest is involved, Plaintiffs must show that: (1) they are likely to succeed on the merits; (2) they are likely to suffer irreparable harm in the absence of preliminary relief; (3) the balance of equities tips in their favor; and (4) an injunction is in the public interest. *Cal. Pharms. Ass'n v. Maxwell-Jolly*, 563 F.3d 847, 849 (9th Cir. 2009) (*California Pharmacists I*) (citing *Winter*, 129 S. Ct. at 376); *see also Am. Trucking Ass'ns, Inc. v. City of Los Angeles.*, 559 F.3d 1046, 1052 (9th Cir. 2009).

I. Likelihood of Success on the Merits

Section 30(A) provides that a State plan must "provide such methods and procedures relating to . . . the payment for . . . care and services . . . as may be necessary . . . to assure that payments are consistent with efficiency, economy, and quality of care." 42 U.S.C. § 1396a(a)(30)(A) (hereafter § 30(A)). In *Orthopaedic,* we held that § 30(A) requires

> the Director [to] set hospital outpatient reimbursement rates that bear a reasonable relationship to efficient and economical hospitals' costs of providing quality services, unless the Department shows some justification for rates that substantially deviate from such costs. To do this, the Department must rely on responsible cost studies, its own or others', that provide reliable data as a basis for its rate setting.

103 F.3d at 1496. The principal issue in this appeal is whether the district court erred in holding that *Orthopaedic* applies to the State's enactment of California Welfare & Institutions Code § 12306.1(d)(6).

As we will explain, both the legislature and the Department recognize that reimbursement rates – that is, providers' wages and benefits – are directly correlated to ensuring that services are consistent with efficiency, economy, and quality of care, and sufficient to ensure access to services under the IHSS program. Following passage of § 12306.1(d)(6), counties, unsurprisingly, reduced the hourly wage paid to IHSS providers. As we explained in *Orthopaedic,*

"*payments* for [Medi-Cal] services must be consistent with efficiency, economy, and quality of care, and . . . those *payments* must be sufficient to enlist enough providers to provide access to Medicaid recipients." 103 F.3d at 1496. Because section 12306.1(d)(6) directly affects what Medi-Cal providers are *paid* for providing services, it falls within § 30(A). Thus, we hold that before enacting legislation that has the effect of lowering payments to providers – here, § 12306.1(d)(6) – the State must study the impact of that decision on the statutory factors set forth in § 30(A). *See California Pharmacists II*, slip op. at 3346.

A. The Application of § 30(A) to Cal. Welf. & Inst. Code § 12306.1(d)(6)

The State argues that *Orthopaedic* does not apply to § 12306.1(d)(6) because that section does not *set* medical reimbursement rates. According to the State, *Orthopaedic* is concerned with ensuring that the State follows adequate procedures to assure that reimbursement rates are consistent with the statutory factors set forth in § 30(A) – efficiency, economy, access, and quality of care. However, § 12306.1(d)(6) neither sets rates, nor changes the procedure in place, i.e., the collective bargaining process, to ensure that wages and benefits paid to IHSS providers are consistent with those statutory factors. Rather, § 12306.1(d)(6) merely lowers the State's *contribution* toward wages and benefits set by the counties pursuant to collective bargaining.

We are not persuaded by the State's attempt to distinguish its rate of *reimbursement* to providers from its *contribution* to the amount counties pay providers in the IHSS context. The State claims that it has removed itself from the rate-setting process and left it up to the counties and providers to negotiate rates through collective bargaining. However, by limiting its contribution to its portion of the non-federal share, the State injects itself *into* the collective bargaining process. Indeed, the statutory cap that the State sets on its contribution provides a powerful bargaining chip to both providers and NPCs or PAs during negotiations over wages and benefits. Prior to § 12306.1(d)(6), providers could seek hourly wages and benefits up to $12.10 knowing that counties would have to contribute just 35 percent of their non-federal share. After the passage of the current § 12306.1(d)(6), providers confront the reality that any hourly wage above $10.10 would be borne entirely by the county.

Similarly, the State argues that the collective bargaining process is an adequate procedure under *Orthopaedic* to assure that rates are consistent with efficiency, economy, and quality of care, and sufficient to ensure access. That may be true, though we note that nothing in the record demonstrates that the Department has conducted any analysis or study regarding the effect of the collectively bargained rates on the statutory factors. But, in any event, Plaintiffs are not challenging those collectively bargained rates, nor are they challenging the collective bargaining process as a method of establishing rates. Rather,

they are challenging the procedural adequacy of the legislature's decision to decrease its funding of those rates. As we have explained, decreasing the amount the State contributes to those rates is as integral to the collective bargaining process as the negotiations themselves, because it directly impacts the amount at which rates will ultimately be set.

The record proves the point in this case. Approximately fourteen counties submitted Rate Change Requests after receiving notice of § 12306.1(d)(6). At least two of those Rate Change Requests expressly state that the decision to reduce the hourly wage for IHSS providers "is due to the change in the State Participation Rate, effective July 1, 2009." These changes demonstrate that the amount the State determines it will contribute to IHSS providers' wages and benefits alters the amount counties are willing to pay IHSS providers for their services – something that the State itself recognized as impacting IHSS recipients' access to services. *See* Cal. Welf. & Inst. Code § 14132.95(j)(2)(C).[6]

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[6] Indeed, in establishing the IHSS program, the State left the bulk of *administrative* duties to the counties. However, before entrusting the counties to administer the program, the State authorized counties to provide for the delivery of IHSS services by either contracting directly with IHSS providers or by establishing NPCs or PAs that would engage with providers in collective bargaining. *See* Cal. Welf. & Inst. Code § 12301.6(c). The State further directed the Department to establish a provider reimbursement rate methodology that would be consistent with the manner in which NPCs and PAs were constituted. *See*

(Continued on following page)

The Department itself has acknowledged the relationship between reimbursement rates and access to in-home supportive services. In the State plan, the Department has articulated its policy that "reimbursement rates for Personal Care Services shall not be less than levels necessary to achieve adequate access to these services, but shall not exceed the lesser of specified limits, consistent with the requirements of [§ 30(A)]." The State plan also provides that "[t]o the extent that the Department finds that sufficient access to services is available, any rate *increases* granted under this program shall be no greater than the funds appropriated by the Legislature for such purpose." (emphasis added). The Department has thus recognized that rate increases are subject to the availability of State funds and has expressly conditioned its approval over such increases on a finding that sufficient access to services is otherwise available. The corollary must also be true. That is, the same oversight exists for any decrease in rates brought about by the availability of State funds. The Department is thus well aware that prior to approving reimbursement rates established through collective bargaining, it must determine whether sufficient access to services is available. *Cf. Orthopaedic,* 103 F.3d at 1497 (rejecting the State's argument that it

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id. § 14132.95(j)(2)(A)(i). In directing the Department to consider a host of relevant factors in establishing its rate-setting methodology, the State recognized that the hourly wage at which providers would be paid would have a direct impact upon "access to services in that county." *Id.* § 14132.95(j)(2)(C).

does not have to pay the costs associated with quality of care because hospitals are required to provide such care as a result of contractual obligations and licensing requirements).

Likewise, the Department has recognized the direct link between the State's change in *contribution* rate and the resulting change in *reimbursement* rates. In April 2009, the Department sent the United States Department of Health and Human Services (HHS) an analysis of § 12306.1(d)(6), providing its arguments as to why § 12306.1(d)(6) did not violate newly enacted requirements of ARRA. That analysis explained the reduction in the State's contribution under § 12306.1(d)(6), including that "funding has been reduced so that the maximum wage participation level will be $10.10 per hour starting July 1, 2009. As a result, the State's conditional approvals of the PA rates are no longer effective and each of the counties in question will need to request the State's approval of another PA rate. . . . If in connection with that a county then chooses to negotiate different wages in excess of the $10.10 maximum wage participation level, it will be doing so voluntarily and not because of any State requirements." Thus, the State explicitly invalidated its prior approval of PA rates, previously negotiated via collective bargaining, as a result of § 12306.1(d)(6).

In any event, the State's obligation to consider whether providers' "payments are consistent with efficiency, economy, and quality of care," § (30)(A), is independent of whatever wages and benefits are set

pursuant to collective bargaining. Notably, in concluding that § 12306.1(d)(6) did not render the State ineligible for increased funding under ARRA, HHS advised the State that if the Department were to approve provider wage rates at a level less than that recommended by the county, "the State would need to assure that the lack of funding from local sources will not result in lowering the amount, duration, scope or quality of care and services available under the plan."

The State argues that there are in excess of 14,000 IHSS providers listed in county registries, implying that there can be no problem with "access" to services following the legislature's decision to cut its contribution to wages and benefits under § 12306.1(d)(6). But the fact that there were 14,000 available IHSS providers in county registries *before* § 12306.1(d)(6)'s rate cut took effect does little to ensure sufficiency of access to quality services after a reduction in wages and benefits. Regardless, as we explained in *Orthopaedic*, "[d]e facto access, produced by factors totally unrelated to reimbursement levels, does not satisfy the requirement of [§ 30(A)]." 103 F.3d at 1498. Sixty-two percent of IHSS recipients receive care from an IHSS provider who is also a relative. Allowing the State to rely on the fact that so many IHSS recipients depend on care from a relative, who may often have no other choice than to provide such services, would allow the State "to ignore the relationship of reimbursement levels to provider costs when determining whether payments are sufficient to ensure access to quality services." *Id.* Moreover, by

focusing on quantity of providers, the State fails to consider potential effects on quality of care.

The State's argument also misses the point. "We do not require plaintiffs to show the State has committed a substantive violation of § 30(A)'s access provision when they can show that the State did not comply with § 30(A)'s procedural components." *California Pharmacists II,* slip op. at 3357. Therefore, whether there were to remain an excess of available IHSS providers in county registries after the decrease in wages and benefits has little bearing on the State's procedural compliance with § 30(A). *See Independent Living II,* 572 F.3d at 657 (discussing this court's "process-oriented view" of § 30(A)).

B. Consideration of Costs

The State next argues that *Orthopaedic* is inapposite to this case because *Orthopaedic* instructs the State to consider the costs to service providers when its sets reimbursement rates, 103 F.3d at 1496, but providers of IHSS services do not have "costs" that can be reimbursed. Rather, sixty percent of providers are spouses, parents, or other relatives of the beneficiaries, and approximately fifty percent live with the recipients they serve. The State contends that it would thus be "virtually impossible" for it to obtain "cost studies" with respect to IHSS services, and so *Orthopaedic,* which holds that states should consider costs, should not apply.

We rejected a similar argument in *Independent Living II*. There, the Director argued that there was "no established mechanism for obtaining cost data from physicians on the costs they incur for providing each of these [covered] services." 572 F.3d at 652 (brackets in original) (internal quotation marks omitted). Having determined that § 30(A) clearly applied to the State's decision to cut providers' reimbursement rates, we rejected the Director's argument, and held that "[i]n the absence of such cost data, the Director could not have complied with § 30(A)." *Id.* The same holds true here. Since we have determined that the State should have studied the impact of its decreased contribution to providers' wages and benefits prior to passing § 12306.1(d)(6), the State is not *ipso facto* immunized from challenges to its actions because it had no system in place to make such an assessment.

Furthermore, there does not seem to be anything inherently difficult about studying IHSS providers' "costs" since there is undoubtedly a way to measure what it costs providers to care for IHSS recipients. The State argues that it cannot study costs because IHSS providers are providing "only their time and labor" and are not paid "rates for specific services, but rather receive hourly wages and benefits for the work they perform." We disagree. The hourly wage paid to an IHSS provider *is* the rate to which they are entitled for providing specific services. *See* Cal. Welf. & Inst. Code § 14132.95(j)(1) ("[R]eimbursement *rates* for personal care services shall be equal to the *rates*

in each county for the same mode of services in the [IHSS] program." (emphases added)). Indeed, those services are expressly enumerated in the governing statute. *See id.* § 12300(b).

In addition, while the State "need not follow a rigid formula," *Orthopaedic*, 103 F.3d at 1498, for determining what it costs providers to care for IHSS recipients, they must rely on something. The State offers nothing to support its assertion that it would be "nonsensical and virtually impossible" to comply with *Orthopaedic's* requirements in the IHSS context. To the contrary, the State concedes that the July 2008 Report to the Legislature, Public Authorities and Nonprofit Consortia in the Delivery of In-Home Supportive Services, SFY 2006/2007 (the July 2008 Report) contains extensive data regarding quality and access in the IHSS system, including: the number of providers available to work on provider registries for each county; data on service shortages and the availability of emergency back-up providers; data on PA/NPC rates and IHSS provider wages and benefits by county; data from provider and consumer satisfaction surveys and PA/NPC surveys; as well as what it costs PAs and NPCs to deliver services. In fact, the State argues that the July 2008 Report satisfies § 30(A)'s requirements – a contention to which we turn below. Yet, the State cannot have it both ways: either it is able to comply with § 30(A), or it is not.

At the very least, the State may look to what it costs providers of analogous services, such as in-home nursing care, as a means of considering providers'

costs. Indeed, in determining the "cap for increases in payment rates for individual practitioner services," the Department is similarly authorized to look to the market rate for "like work in each county." Cal. Welf. Inst. Code § 14132.95(j)(2)(C)(i).

Accordingly, we hold that the district court did not err in holding that § 30(A) applies to the State's enactment of § 12306.1(d)(6).

C. State Compliance with § 30(A)

Next, the State argues that while it was under no obligation to do so, it complied with everything that *Orthopaedic* requires by preparing the 2008 Report. The district court did not consider this report because it believed that the State conceded that the legislature did not consider § 30(A) prior to enacting § 12306.1(d)(6).

We agree that, at oral argument before the district court, the State conceded that the legislature did not consider any analysis of the § 30(A) factors prior to enacting § 12306.1(d)(6). Not only did the State fail to raise this claim before the district court, thus waiving the issue, *see United States v. Flores-Montano*, 424 F.3d 1044, 1047 (9th Cir. 2005) (issues not raised to the district court are normally deemed waived subject to three "narrow exceptions"), it took the position that any consideration of § 30(A) would be impossible.

In any event, the 2008 Report is inadequate for purposes of § 30(A). Nowhere does the 2008 Report contain any references to § 12306.1(d)(6), let alone "study the impact of the contemplated rate change(s) on the statutory factors *prior to* setting rates, or in a manner that allows those studies to have a meaningful impact on rates before they are finalized." *California Pharmacists II*, slip op. at 3360-61. Rather, the 2008 Report is the annual report that DSS is statutorily required to provide the legislature, regarding the efficacy of counties' elections to establish a PA or contract with an NPC to deliver services. *See* Cal. Welf. & Inst. Code § 12301.6(o). While the annual report includes assessments of the quality of care being provided in the IHSS program, it contains no discussion of a contemplated rate change that would either increase or decrease payment rates. Finally, in the report on which the State relies, forty-three percent of PA/NPCs reported a "critical shortage of available providers that affected a specific subpopulation of IHSS consumers." That conclusion belies the State's assertion that current wages and benefits – those in effect prior to passage of § 12306.1(d)(6) – are consistent with § 30(A)'s statutory factors.

II. Irreparable Harm

The State next argues that the district court erred in concluding that Plaintiffs established irreparable harm absent injunctive relief. In holding that Plaintiffs made a sufficient showing of irreparable harm, the district court made two factual findings,

which we review for clear error. *Earth Island Inst.*, 442 F.3d at 1156. First, the district court held that wage reductions would cause IHSS providers to leave employment, leaving IHSS recipients without IHSS assistance. Second, the district court concluded that IHSS providers would also suffer immediate and irreparable harm, due to the fact that a reduction in providers' wages and benefits would result in financial injury that providers would be unable to recover due to the State's Eleventh Amendment immunity.

On appeal, the State's primary argument is that Plaintiffs failed to submit any credible evidence that a reduction in the State's contribution, resulting in a decrease in wages to IHSS providers, would cause IHSS recipients to go without care. However, the State takes no position on whether Plaintiffs may establish irreparable injury to IHSS *providers* as opposed to IHSS *recipients*. As we stated in *California Pharmacists II*, to show a likelihood of irreparable injury, "plaintiffs need only show harm to Medi-Cal service providers or their members." Slip op. at 3358; *see also California Pharmacists I*, 563 F.3d at 850. Here, Plaintiffs have submitted ample evidence of harm to IHSS providers, including that fourteen counties have sought to reduce wages and benefits in the wake of § 12306.1(d)(6), which would impact many providers' ability to afford such basic necessities as food, clothing, utilities, and rent. Accordingly, we hold that the district court did not abuse its discretion in concluding that Plaintiffs established irreparable harm absent injunctive relief, as its

finding regarding provider harm was not clearly erroneous.

III. Balance of Equities and the Public Interest

As to the final two elements necessary to obtain a preliminary injunction in a case in which the public interest is involved, we have repeatedly recognized that individuals' interests in sufficient access to health care trump the State's interest in balancing its budget. *See Independent Living II*, 572 F.3d at 659; *California Pharmacists II*, slip op. at 3360. (recognizing the important public interest in social welfare cases of safeguarding access to health care for Medicaid-eligible individuals). We continue to do so here, especially in light of evidence in the record that suggests that reductions in providers' wages and benefits may have an adverse, rather than beneficial, effect on the State's budget, such that it would actually save the State money if it maintained its current level of funding of the IHSS program. *See California Pharmacists I*, 563 F.3d at 852 (balance of equities and public interest weighed in favor of Medi-Cal providers where the impact of the injunction on the State's budget crisis would be minimal).

The State argues that if this injunction is upheld, "it will be unclear whether the State may ever undertake any action to reduce its payments" to Medi-Cal service providers. This statement wholly misreads our Medicaid jurisprudence. If the State makes a

policy decision to decrease providers' reimbursement rates, and fully complies with the requirements of this and our other decisions, it will not be barred by current federal Medicaid law from doing so. Accordingly, we hold that the district court did not abuse its discretion in concluding that the balance of hardships and the public interest weighed in favor of enjoining implementation of California Welfare & Institutions Code § 12306.1(d)(6).

CONCLUSION

The district court properly determined that § 30(A) of the Medicaid Act applies to the State's enactment of California Welfare & Institutions Code § 12306.1(d)(6). The district court correctly held that Plaintiffs demonstrated a likelihood of success on the merits of their Supremacy Clause claim, and did not abuse its discretion in holding that the balance of hardships tips sharply in Plaintiffs' favor. Accordingly, we affirm the district court's order granting the motion for a preliminary injunction.

AFFIRMED.

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
WESTERN DIVISION

California Pharmacists Association, et al. Plaintiff(s), vs. David Maxwell Jolly Defendant.	Case No. CV 09-722 CAS (MANx) **ORDER GRANTING PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION AS TO ADULT DAY HEALTH CENTERS** (Filed Mar. 9, 2009)

I. INTRODUCTION AND BACKGROUND

On September 16, 2008, the California Legislature passed Assembly Bill 1183 ("AB 1183"), which was subsequently signed by the Governor and filed with the Secretary of State on September 30, 2008. AB 1183, *inter alia*, amends Cal. Welf. & Inst. Code. § 14105.191 and §14166.245, mandating that, for dates of service on or after March 1, 2009, Medi-Cal reimbursement payments to some fee-for-service providers are reduced by one percent, five percent, or ten percent, depending on provider type. Particularly relevant to the instant action, AB 1183 mandates a five percent rate reduction for Medi-Cal fee-for-service benefits paid to pharmacies and Adult Day Health Centers ("ADHCs").

These reductions mandated in AB 1183 replace the ten percent rate reduction put into place by Assembly Bill X35 ("AB 5"), which terminates on February 28, 2009. *See* Cal. Welf. & Inst. Code § 14105.19(b)(1). AB 5 was passed by the California Legislature on February 16, 2008. On August 18, 2008, the ten percent rate reduction mandated by AB 5 was partially enjoined by this Court in a related action, *Independent Living Center of Southern California, Inc. v. Sandra Shewry*, CV-08-3315-CAS. In issuing the preliminary injunction, this Court found that petitioners had, *inter alia*, demonstrated a strong likelihood of success in showing that AB 5 was preempted by § 30(A) of the Medicaid Act (referred to herein as "§ 30(A)"). The Court's August 18, 2008 order is currently being appealed to the Court of Appeals for the Ninth Circuit.[1]

On January 29, 2009, plaintiffs California Pharmacists Association; California Medical Association; California Dental Association; California Hospital Association; California Association for Adult Day

[1] The Court's August 18, 2008 order was issued on remand from the Ninth Circuit, after plaintiffs appealed this Court's original June 25, 2008 ruling on their preliminary injunction motion. The Court's June 25, 2008 order found that plaintiffs in Independent Living lacked any federal rights under § 30(A), and therefore had denied petitioners' motion for preliminary injunction. On appeal, the Ninth Circuit held that plaintiffs could bring suit under the Supremacy Clause to enjoin AB 5 as preempted under the Medicaid Act, and remanded to this Court. *See Independent Living Center of Southern California et al. v. Sandra Shewry et al.*, 543 F.3d 1050 (9th Cir. 2008).

Services; Marin Apothecary, Inc.; South Sacramento Pharmacy; Farmacia Remedios, Inc.; Acacia Adult Day Services; Sharp Memorial Hospital; Grossmont Hospital Corporation; Sharp Chula Vista Medical Center; Sharp Coronado Hospital and Healthcare Center; Fey Garcia; and Charles Gallagher filed the instant action against David Maxwell-Jolly, Director of the Department of Health Care Services of the State of California. Plaintiffs' complaint challenges the AB 1183 Medi-Cal reimbursement rate reductions to various providers.

On February 11, 2009, plaintiffs filed the instant motion for a preliminary injunction. Specifically, plaintiffs seek an order for a preliminary injunction restraining and enjoining the defendant from reducing Medi-Cal fee-for-service rates to pharmacies and adult day health care centers ("ADHCs") pursuant to AB 1183.

On February 27, 2009, this Court issued an injunction in the related case *Managed Pharmacy Care, et al. v. David Maxwell-Jolly,* CV09-382-CAS, ordering defendant "Director, his agents, servants, employees, attorneys, successors, and all those working in concert with him to refrain from enforcing Cal. Welf. & Inst. Code § 14105.191(b)(3), as modified by AB 1183 beginning on March 1, 2009, by refraining from reducing by five percent payments to pharmacies for prescription drugs (including prescription drugs and traditional over-the-counter drugs provided by prescription) provided under the Medi-Cal fee-for-service program." Therefore, the Court considers

plaintiffs' request for an injunction as to pharmacies to be moot, and considers herein only their request for injunction as to ADHCs.[2]

On February 26, 2009, defendant filed an opposition to plaintiff's motion for preliminary injunction. A reply was filed on March 4, 2009. After carefully considering the arguments set forth by the parties, the Court finds and concludes as follows.

II. LEGAL STANDARD

A preliminary injunction is appropriate when the moving party shows either (1) a combination of probable success on the merits and the possibility of irreparable harm, or (2) the existence of serious questions going to the merits and that the balance of hardships tips sharply in the moving party's favor.

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[2] In *Managed Pharmacy Care, et al. v. David Maxwell-Jolly*, CV09-382-CAS, plaintiffs' arguments regarding irreparable harm focused on brand and generic drugs dispensed by pharmacies. The Court therefore found that plaintiffs had not shown irreparable harm as to the effect of the five percent rate reduction on other pharmacy products, and limited the scope of the injunction to drug products dispensed by pharmacies.

In their reply, plaintiffs request that the Court rule on the merits of their motion for injunction as to pharmacies, arguing that the scope of the injunction requested in the instant action is broader than that granted in *Managed Pharmacy Care*, CV09-382-CAS. However, plaintiffs offer no basis for extending the scope of the injunction as to pharmacies issued in *Managed Pharmacy Care*, and, after examining the evidence submitted by plaintiffs in the instant action, the Court finds no basis for such an extension.

See Rodeo Collection, Ltd. v. West Seventh, 812 F.2d 1215, 1217 (9th Cir. 1987). These are not two distinct tests, but rather "the opposite ends of a single 'continuum in which the required showing of harm varies inversely with the required showing of meritoriousness.'" *Id.* A "serious question" is one on which the movant "has a fair chance of success on the merits." *Sierra On-Line, Inc. v. Phoenix Software, Inc.*, 739 F.2d 1415, 1421 (9th Cir. 1984).

III. DISCUSSION

A. ELEVENTH AMENDMENT AND PRUDENTIAL STANDING

Before addressing the merits of plaintiffs' argument for preliminary injunction, the Court must first address two arguments raised by defendant: (1) that plaintiffs' suit is barred by the Eleventh Amendment and (2) that plaintiffs lack standing. The Court finds that neither of these arguments is persuasive.

The essence of defendant's Eleventh Amendment argument is that plaintiffs' suit effectively amounts to a request for money damages to be paid out of the state treasury, in violation of the Eleventh Amendment. *See* Opp'n at 25, n.22 ("Plaintiffs seek to recover money against the State for funds above the 5% payment reduction"), citing *Edelman v. Jordan*, 415 U.S. 651 ("Thus the rule has evolved that a suit by private parties seeking to impose a liability which must be paid from public funds in the state treasury is barred by the Eleventh Amendment"). However,

the Court disagrees with defendant's characterization of plaintiffs' claim. Plaintiffs complaint does not seek money damages, but instead seeks only prospective injunctive relief – namely, an injunction preventing defendant from enforcing a state law that, defendants argue, is preempted by the Medicaid Act. Such prospective injunctive relief against a state official is permissible under *Ex Parte Young*, 209 U.S. 123 (1908), even where such an injunction will have an effect on the state treasury. *See, e.g., Milliken v. Bradley*, 433 U.S. 267 (federal courts permitted "to enjoin state officials to conform their conduct to requirements of federal law, notwithstanding a direct and substantial impact on the state treasury").

Defendant also argues that plaintiffs lack prudential standing, because they are health care providers who have no "rights" under the federal law they seek to enforce. Opp'n at 25, n.22. The Court disagrees. In its September 17, 2008 order in the related action *Independent Living*, 543 F.3d at 1065, the Ninth Circuit determined that petitioners in that action had standing:

> Petitioners include independent pharmacies and health care providers participating in the State's Medi-Cal program that, according to their complaint, will be directly injured, by loss of gross income, when the ten-percent rate reduction takes effect. The Supreme Court repeatedly has recognized that such [direct economic] injuries establish the threshold requirements of Article III standing. Moreover, this injury is directly traceable to

> the Director's implementation of AB 5, and would certainly be redressed by a favorable decision of this court enjoining the ten-percent rate reduction.

As in *Independent Living*, plaintiffs in the instant action include ADHC providers, who, plaintiffs allege, would be directly injured by the five percent Medi-Cal reimbursement rate reduction.

Furthermore, the Ninth Circuit in *Independent Living* noted that

> petitioners also include several individual Medi-Cal beneficiaries, who will be injured or put at risk of injury by implementation of the 10% provider payments cuts because those cuts will reduce quality services, and access to quality services. This injury, like the injury to medical providers discussed above, is the direct result of the Director's implementation of AB 5, and would certainly be remedied by a decision granting injunctive relief. Such an injury to those individuals most directly affected by the administration of [a state welfare] program is sufficient to allow petitioners to seek injunctive relief in federal court.

2008 U.S. App. LEXIS 19725 (9th Cir. 2008). Because plaintiffs in this case also include Medi-Cal beneficiaries who may be harmed by AB 1183 rate reductions, the Court finds defendant's argument that plaintiffs lack standing to be without merit.

B. LIKELIHOOD OF SUCCESS ON THE MERITS

Pursuant to the holding of the Ninth Circuit in the related action *Independent Living*, 543 F.3d at 1065, the Court finds, as an initial matter, that plaintiffs may pursue a claim for relief under the Supremacy Clause based on the allegation that AB 1183 is preempted by § 30(A). Here, plaintiffs' Supremacy Clause claim is predicated upon federal conflict preemption. Under general principles of federal preemption, state law is preempted only to the extent that it actually conflicts with federal law. *Pacific Gas & Elec. Co. v. State Energy Comm'n*, 461 U.S. 190, 204 (1983). Such a conflict may arise either where "compliance with both federal and state regulations is a physical impossibility, or where state law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." *Id.* at 203-04 (citations omitted).

Thus, to prevail on the merits plaintiffs will have to prove either that it is not possible for the Department to comply with both AB 1183 and the Medicaid Act or that AB 1183 stands as an obstacle to the enforcement of § 30(A). As such, the Court turns to the statutory provisions at issue here.

The "quality of care" provision of § (30)(A) provides that:

> [a] State plan for medical assistance must . . . provide such methods and procedures relating to the utilization of, and the

> payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care.

42 U.S.C. § 1396a(30)(A). The "equal access" provision of § 30(A) provides that:

> [a] State plan for medical assistance must . . . provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are . . . sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

Id.

In *Orthopaedic Hospital v. Kizer,* 1992 WL 345652 (C.D. Cal. 1992) ("*Orthopaedic I*"), plaintiff-hospital providers filed suit pursuant to 42 U.S.C. § 1983 ("§ 1983"), claiming that the Director violated § 30(A) by setting reimbursement rates for hospital outpatient services without considering the effect of hospital costs on efficiency, economy, and quality of

care.[3] *Id.* at *1. The district court concluded that § 30(A) was enforceable in a § 1983 action, and that the Department "had a judicially enforceable obligation" to consider and make findings each time it modified reimbursement rates. *Id.* at *2. According to the district court, § 30(A) obligated the Department to consider efficiency, economy, and quality of care, which it referred to as the "relevant factors." *Id.* at *4. The district court found that the Director had acted arbitrarily and capriciously in establishing six of the seven challenged rates. *Id.* The court then remanded the matter to the Department for further consideration. *Id.* at *14. Upon remand, the Department conducted a rate study, and readopted the reimbursement rates without change. *Orthopaedic Hospital II/III*, 103 F.3d at 1495.

The hospitals returned to the district court, filing two lawsuits (*Orthopaedic II/III*) that the district court consolidated, arguing that the adopted rates did not comply with § 30(A). *Id.* The district court entered judgment in favor of the Department, finding that the Department was not statutorily required to consider hospital costs when setting reimbursement rates. *Id.* The hospitals appealed, and the Ninth Circuit reversed. The Ninth Circuit's interpretation held that § 30(A) "provides that payments for services must be consistent with efficiency, economy, and quality of

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[3] The hospitals did not, however, challenge the rates under the "equal access" provision. *Orthopaedic I*, 1992 WL 345652 at *14 n.4.

care, and that those *payments* must be sufficient to enlist enough providers to provide access to Medicaid recipients." *Id.* at 1496 (emphasis in original). The Ninth Circuit therefore concluded that under § 30(A)

> the Director must set hospital outpatient reimbursement rates that bear a reasonable relationship to efficient and economical hospitals' costs of providing quality services, unless the Department shows some justification for rates that substantially deviate from such costs. To do this, the Department must rely on responsible cost studies, its own or others', that provide reliable data as a basis for its rate setting.

Id.[4] Further, the Ninth Circuit found that "[i]t is not justifiable for the Department to reimburse providers substantially less than their costs for purely budgetary reasons." *Id.* at 1499 n.3.[5]

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[4] *See e.g., Alaska Dep't of Health & Soc. Servs. v. Ctrs. for Medicare & Medicaid Servs.*, 424 F.3d 931, 940-41 (9th Cir. 2005); *see also Arkansas Med. Soc'y v. Reynolds*, 6 F.3d 519, 530 (8th Cir. 1993) ("We agree with the trial court's conclusion that the relevant factors that DHS is obliged to consider in its rate-making decisions are the factors outlined in 42 U.S.C. § 1396a(a)(30)(A)."); *cf. Methodist Hosps. v. Sullivan*, 91 F.3d 1026, 1030 (7th Cir. 1996) (finding that § 30(A) does not require a state to consider any particular factors, but rather, requires that the state arrive at substantive results consistent with the Medicaid Act); *Rite Aid, Inc. v. Houstoun*, 171 F.3d 842 (3d Cir. 1999) (same).

[5] Subsequently, in *Sanchez v. Johnson*, 416 F.3d 1051 (9th Cir. 2005), the Ninth Circuit held that § 30(A) does not confer

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Whatever else its effect may have been, it is clear that *Sanchez v. Johnson*, 416 F.3d 1051 (9th Cir. 2005) left undisturbed the rule announced in *Orthopaedic II/III* that § 30(A) creates duties on behalf of the Department, i.e., the duty to consider efficiency, economy, and quality of care when establishing reimbursement rates. Indeed, the *Sanchez* court recognized that "[§ 30(A)] speaks . . . of the *State's obligation* to develop 'methods and procedures' for providing services generally." *Sanchez*, 416 F.3d at 1059 (emphasis added).

Because *Orthopaedic II/III* is binding authority on this Court, the Court finds that when the State of California seeks to modify reimbursement rates for health care services provided under the Medi-Cal program, it must consider efficiency, economy, and quality of care, as well as the effect of providers' costs on those relevant statutory factors.

In the instant motion for preliminary injunction, plaintiffs argue that AB 1183's five percent reimbursement rate reduction to ADHCs is preempted by § 30(A), because the Legislature did not consider any

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individual rights that are enforceable under 42 U.S.C. § 1983. *Id.* at 1060. However, in *Independent Living*, 543 F.3d 1050 (9th Cir. 2008), the Ninth Circuit held that "a plaintiff seeking injunctive relief under the Supremacy Clause on the basis of federal preemption need not assert a federally created 'right,' in the sense that term has been recently used in suits brought under § 1983, but need only satisfy traditional standing requirements." *Independent Living*, 543 F.3d 1050, 1058 (9th Cir. 2008).

of the relevant factors as required by *Orthopaedic II/III*. Specifically, plaintiffs argue that the legislative history indicates that the bill was passed solely for budgetary reasons, arguing that "AB 1183's legislative history presents no evidence that the Legislature made any consideration of efficiency, economy, quality of care, and equality of access, as well as the effect of providers' costs on those relevant statutory factors in the 24-hour period between AB 1183's amendment and its passage." Mot. at 13.

Defendants, however, argue that the requirements of *Orthopaedic II/III* are in fact satisfied, because the Department itself performed a detailed analysis of the relevant factors. Specifically, defendant submits the Department's report "Analysis of Assembly Bill 1183 Medi-Cal Reimbursement for Adult Day Health Care Centers," ("Department ADHC Analysis"), completed in February 2009, well after the enactment of AB 1183 on September 16, 2008. Opp'n at 11. The Department ADHC Analysis concludes that:

> After a 5% payment reduction is implemented on March 1, 2009, Medi-Cal reimbursement paid to ADHCs will comply with title 42, United States Code, section 1396(a)(30)(A). The available data indicates that Medi-Cal recipients will continue to have sufficient access to ADHC services to the extent required by federal law. In fact they will actually have far better access to ADHC services than the general population does . . . The 5% payment reduction will

> result in more efficient and economical Medi-Cal coverage. It will not have any negative impact for Medi-Cal recipients. The number of ADHCs participating in Medi-Cal has tripled since 1998 and 94% of all licensed ADHCs are actively enrolled in Medi-Cal. Finally, the Department determined that Medi-Cal reimbursement will in the aggregate compensate provider costs at a level that is well above the 'range of reasonableness' that was acceptable under the repealed Boren Amendment. Thus, reduced reimbursement will be sufficient under the more flexible requirements of section 1396(a)(30)(A).

Department ADHC Analysis at 10-11.

Plaintiffs, however, argue that the Department's post-hoc analysis does not satisfy the requirements of *Orthopaedic II/III*. The Court agrees. First, the Court notes that AB 1183, as passed by the Legislature, does not provide the Department with any discretion to determine whether the five percent rate reduction should be implemented based on the Department's consideration of the relevant factors. *See* Cal. Welf. & Inst. Code. § 14105.191 ("Notwithstanding any other provision of law, or order to implement changes in the level of funding for health care services, the *director shall reduce* provider payments, as specified in this section . . . ") (emphasis added). In *Orthopaedic II/III*, in which rates set by the Department, rather than the Legislature, were at issue, the court stated that the "the Department must rely on responsible cost

studies, its own or others', that provide reliable data *as a basis* for its rate setting." 103 F.3d at 1496 (emphasis added); *see also id.* at 1499-1500 ("Since the Department did not adequately consider hospitals' costs *when readopting its rates*, the Department's actions were arbitrary and capricious and contrary to law") (emphasis added). The *Orthopaedic II/III* holding therefore indicates that the body responsible for rate setting must consider the relevant factors contemporaneously with the adoption of the rates. Because the Department has no authority to alter the rate reduction imposed by the Legislature, the Department's post hoc analysis does not satisfy the requirements of *Orthopaedic II/III*.

Furthermore, in this case, it does not appear that the Legislature appropriately considered any of the relevant factors before passing AB 1183. Defendant responds to plaintiffs' arguments that the legislature did not perform the required analysis by submitting evidence indicating that (1) between May 2008 and September 2008, Department employees provided information to legislative staff members concerning the rate reductions; (2) in June 2008, the Subcommittee 3 Health Human Services, Labor, and Veterans Affairs Major Action Report included modifications and rejections of certain rate reductions proposed by the Administration; and (3) in July 2008, the Summary Overview Budget Conference Committee Report includes discussions of the rate reductions. *See* Trueworthy Decl. ¶ 5, Exs. A-E. However, none of this demonstrates that the Legislature relied on

responsible cost studies providing reliable data in setting the rates. *See Orthopaedic Hospital II/III,* 103 F.3d at 1496. Furthermore, even if a post hoc analysis of the relevant factors was sufficient, the Court is not persuaded that the analysis actually conducted by the Department was adequate, given that the Department relied on NF-A data, which may not be an adequate proxy for ADHC costs. Reply at 12.

Therefore, because it appears that the Legislature and the Department did not properly consider the relevant factors prior to the passage of the five percent rate reduction in AB 1183, the Court finds that plaintiffs have a strong likelihood of success on the merits.

C. IRREPARABLE HARM

The next question before this Court is whether plaintiffs have shown that Medi-Cal beneficiaries will be irreparably harmed if the five percent rate reduction to ADHCs is permitted to go into effect. Defendant argues that plaintiffs cannot show irreparable harm resulting from the five percent rate reduction to ADHCs, given that the Department ADHC Analysis estimates that after AB 1183, ADHCs will be compensated at a level above 100 percent of necessary and reasonable ADHC costs.[6] Mot. at 16-17;

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[6] The Department states that because it is in the process of auditing costs of ADHCs, it is not able to assess how current ADHC reimbursement in the aggregate compares to the

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Department ADHC Analysis at 8. Furthermore, with regard to access, defendants argue that, because Medicare and other health insurance plans do not cover ADHC services, ADHC services are not generally available to the general population, and therefore, "[p]laintiffs cannot meet their burden of proving that any payment reduction, let alone a 5% payment reduction, is going to affect access to services to which the general population has limited access in the first place." Mot. at 17; *see* Ferreria Decl. ¶ 3. In addition, defendant argues that, since 1998, an additional 212 ADHCs have enrolled in the Medi-Cal program, indicating that "for profit" ADHCs have found the reimbursement rate to be sufficiently profitable to join and remain in the Medi-Cal program. Mot. at 17; Department ADHC Analysis at 10. Finally, the Department's ADHC Analysis found that when the ten percent rate reduction was in effect between July 1, 2008 and August 17, 2008, there was only a two percent decrease in paid ADHC claims compared to a similar period the prior year, indicating that a more moderate reduction will not result in a decrease in access. Mot. at 18; ADHC Analysis at 10.

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reasonable and allowable costs that ADHCs incur. *See* Eng Decl. ¶ 4. Therefore, the Department's analysis uses as a proxy the costs of intermediate care facilities ("NF-As"). Plaintiff disputes the validity of this proxy, arguing that there is no basis for equating the costs of NF-As with the costs of ADHCs. Reply at 12.

Plaintiffs, however, submit declarations from ADHC providers which, they argue, indicate that ADHC provider costs currently exceed the reimbursement rate of $76.22 per patient participant ("participant") per day, and that the five percent rate reduction will serve to exacerbate this disparity. Mot. at 18; *see* Kauffman Decl. ¶ 6 (costs are $97.48 per participant per day); Vega Decl. ¶ 10 (costs are $95 per participant per day; five percent rate reduction will increase daily per participant deficit from $18.78 to $22.59); Regalia Decl. ¶ 7 (costs are $102 per participant per day). Plaintiffs further submit evidence that many ADHCs have closed in recent years due to financial pressures. Mot. at 18; Puckett Decl. ¶ 5 (closure of ADHC site in 2007 due to failure of Medi-Cal reimbursement to keep pace with costs); Vega Decl. ¶ 6 (Orange County ADHC closed in 2007 due to unmet costs by Medi-Cal). Plaintiffs argue that the declarations of ADHC providers indicate that many more ADHCs may be forced to close as a result of the AB 1183 rate reductions. Puckett Decl. ¶ 12 (five percent cut "threatens the very existence of our program"); Vega Decl. ¶ 11 (changes in Medi-Cal reimbursement places ADHC in jeopardy of closing.); Kauffman Decl. ¶¶ 8-10; Nolcox Decl. ¶ 9. Other ADHCs, plaintiffs argue, would be forced to take on fewer participants, meaning that some unserved Medi-Cal beneficiaries may be forced to enter a nursing home. Puckett Decl. ¶ 11 (as a result of AB 1183 reductions, ADHC cannot provide participants with transportation and will have to delay admissions); Kauffman Decl. ¶ 9 (reimbursement rate

reductions will force ADHC to make additional cutbacks to services and staff); Davis Decl. ¶¶ 5-7. Furthermore, plaintiff argues that the rate reduction will force ADHC participants to receive care in higher cost settings, such as emergency rooms and skilled nursing facilities, and that, due to shortages in skilled nursing facilities, some participants will be forced into institutions far from their families. Mot. at 20; Missaelides Decl. ¶¶ 20-21; Kauffman Decl. ¶¶ 10-11; Puckett Decl. ¶ 12; Pl's RJN Ex. 6 (Legislative Analyst's Office Analysis of 2008-09 Budget) at C-39 ("if rate reductions force Adult Day Health Care Centers to close, beneficiaries who rely on services provided by the centers to stay in their homes may be forced to enter into relatively more costly nursing homes or other assisted living facilities"). Plaintiffs also argue that plaintiffs Charles Gallagher and Fe Garcia, who both attend ADHC's, would be irreparably harmed if their ADHCs were to close. Mot at 22-23; Gallagher Decl. ¶¶ 7-8; Garcia Decl. ¶¶ 2, 4.

The Court finds that the evidence submitted by plaintiffs indicate that Medi-Cal beneficiaries are at risk of losing access to ADHC services due to the AB 1183 rate reduction. Furthermore, the Court is not convinced that the Department's data comparing the number of Medi-Cal claims under AB 5 to the previous year demonstrates that the rate reductions will not affect access, given that this data reflects claims immediately after the AB 5 rate reductions were implemented, when the full effect of the rate reduction might not yet have been felt by ADHCs. *See*

Reply at 18. Therefore, the Court finds that plaintiffs have established sufficient irreparable harm so as to warrant an injunction.

D. BALANCE OF HARDSHIPS

The Court is mindful of the difficulty facing the State of California in light of its fiscal crisis.[7] However, the State has accepted federal funds under the Medicaid Act. In so doing, the State agreed to abide by the conditions imposed by Congress. Further, retroactive relief for Medi-Cal beneficiaries will likely be inadequate and, and it will come too late, to remedy their pain, suffering, and harm to their mental and physical well-being. *See e.g., Lopez v. Heckler,* 713 F.2d 1432, 1437 (9th Cir. 1983). In light of the significant threat to the health of Medi-Cal recipients, reducing payments to health-care service providers will likely cause, and given that nothing in this Court's order prevents respondent from imposing a rate reduction after she has appropriately considered and applied the relevant factors, the Court finds that the balance of hardships tips in favor of granting the preliminary injunction.

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[7] Furthermore, if the five percent rate reduction is given effect, many Medi-Cal beneficiaries may turn to more costly forms of medical care, such as emergency room care, thereby diminishing the State's projected savings. *See e.g., Rodde v. Bonta,* 357 F.3d 988, 999 (9th Cir. 2004).

E. PUBLIC INTEREST

"The district court's public interest analysis should be whether there exists some critical public interest that would be injured by the grant of preliminary relief." *Hybritech,* 849 F.2d at 1458. Clearly, there is a public interest in ensuring that the State has enough money to meet its financial obligations in the face of competing demands. However, there is also a public interest in ensuring access to health care. In light of all the circumstances, including the fact that the State may decide to implement a rate change upon making a properly reasoned and supported analysis, the Court finds that the public interest does not weigh against the issuance of a preliminary injunction.

IV. CONCLUSION

For the foregoing reasons, the Court GRANTS plaintiffs' motion for preliminary injunction. The Court hereby orders respondent Director, his agents, servants, employees, attorneys, successors, and all those working in concert with him to refrain from enforcing Cal. Welf. & Inst. Code § 14105.191, as modified by AB 1183 beginning on March 9, 2009, by refraining from reducing by five percent payments to ADHCs provided under the Medi-Cal fee-for-service program.

IT IS SO ORDERED.

Dated: March 9, 2009 /s/ Christina A. Snyder
CHRISTINA A. SNYDER
UNITED STATES
DISTRICT JUDGE

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
WESTERN DIVISION

California Pharmacists Association, et al. Plaintiffs, vs. David Maxwell Jolly Defendant.	Case No. CV 09-722 CAS (MANx) **ORDER DENYING PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION AS TO HOSPITALS** (Filed Mar. 9, 2009)

I. INTRODUCTION AND BACKGROUND

On September 16, 2008, the California Legislature passed Assembly Bill 1183 ("AB 1183"), which was subsequently signed by the Governor and filed with the Secretary of State on September 30, 2008. AB 1183, *inter alia*, amends Cal. Welf. & Inst. Code. § 14105.191 and § 14166.245, mandating that, effective March 1, 2009, Medi-Cal reimbursement payments to some fee-for-service providers will be reduced by one percent, five percent, or ten percent, depending on provider type.

These reductions mandated in AB 1183 replace the ten percent rate reduction put into place by Assembly Bill X3 5 ("AB 5"), which terminated on February 28, 2009. *See* Cal. Welf. & Inst. Code § 14105.19(b)(1). AB 5 was passed by the California Legislature on February 16, 2008. On August 18,

2008, the ten percent rate reduction mandated by AB 5 was partially enjoined by this Court in a related action, *Independent Living Center of Southern California, Inc. v. Sandra Shewry*, CV-08-3315-CAS. In issuing the preliminary injunction, this Court found that petitioners had, *inter alia*, demonstrated a strong likelihood of success in showing that AB 5 was preempted by § 30(A) of the Medicaid Act (referred to herein as "§ 30(A)"). The Court enjoined the rate reduction as to physicians, dentists, pharmacies, adult day health care centers ("ADHCs"), and clinics. However, the Court did not enjoin the rate reduction as to non-contract hospitals, finding that plaintiffs had not presented sufficient evidence of irreparable harm to those providers. The Court's August 18, 2008 order is currently being appealed to the Court of Appeals for the Ninth Circuit.[1]

On January 29, 2009, plaintiffs California Pharmacists Association; California Medical Association; California Dental Association; California Hospital Association; California Association for Adult Day

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[1] The Court's August 18, 2008 order was issued on remand from the Ninth Circuit, after plaintiffs appealed this Court's original June 25, 2008 ruling on their preliminary injunction motion. The Court's June 25, 2008 order found that plaintiffs in *Independent Living* lacked any federal rights under § 30(A), and therefore had denied petitioners' motion for preliminary injunction. On appeal, the Ninth Circuit held that plaintiffs could bring suit under the Supremacy Clause to enjoin AB 5 as preempted under the Medicaid Act, and remanded to this Court. *See Independent Living Center of Southern California et. al. v. Sandra Shewry et al.*, 543 F.3d 1050 (9th Cir. 2008).

Services; Marin Apothecary, Inc.; South Sacramento Pharmacy; Farmacia Remedios, Inc.; Acacia Adult Day Services; Sharp Memorial Hospital; Grossmont Hospital Corporation; Sharp Chula Vista Medical Center; Sharp Coronado Hospital and Healthcare Center; Fey Garcia; and Charles Gallagher filed the instant action against David Maxwell-Jolly, Director of the Department of Health Care Services of the State of California. Plaintiffs' complaint challenges the AB 1183 Medi-Cal reimbursement rate reductions to various providers.

On February 11, 2009, plaintiffs filed the instant motion for a preliminary injunction. Plaintiffs seek an order for a preliminary injunction restraining and enjoining the defendant from reducing Medi-Cal fee-for-service rates to hospitals pursuant to Assembly Bill 1183. Defendant filed an opposition thereto on February 26, 2009. A reply was filed on March 4, 2009. After carefully considering the arguments set forth by the parties, the Court finds and concludes as follows.

II. HOSPITAL REIMBURSEMENT BEFORE AND AFTER AB 1183

In their motion, plaintiffs distinguish between four distinct types of hospital services, for which Medi-Cal reimbursement rates are determined in different ways: (1) inpatient services, (2) outpatient services, (3) Distinct Part Nursing Facilities ("DP/NF's"), and (4) subacute services.

The reimbursement rates for inpatient services at issue in this motion are those provided to a specific type of hospital, known as a "non-contract hospitals." In 1982, the California Legislature authorized the Department to enter into contracts with certain hospitals for inpatient services, under the selective provider contracting program ("SPCP"). Mot at 3; *See* Cal. Welf Inst. Code §§ 14081 *et seq.* Hospitals with SPCP contracts are referred to as "contract hospitals" and are generally reimbursed for Medi-Cal at per diem rates, which are negotiated by the California Medical Assistance Commission ("CMAC"). Mot. at 3; Opp'n at 7; Chell Decl. ¶¶ 3, 5. Reimbursement rates to contract hospitals are not affected by AB 1183. By contrast, non-contract hospitals operating outside of a geographic area where a contract hospital exists are reimbursed for inpatient services to Medi-Cal patients, at a rate equaling the lowest of (1) its customary charge, (2) its reasonable costs determined using Medicare principles, (3) an all-inclusive rate per discharge determined by computing a base year cost per discharge and then limiting annually increases to the base rate, or (4) the 60th percentile rate per discharge of the hospitals in its "peer group."[2] [3] Mot. at 3; Opp'n at 8.

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[2] By contrast, where non-contract hospitals are located in the same geographic area (known as a Health Facility Planning Area) where contract hospitals are providing adequate services to the area's populations, the hospitals not covered by a contract will be reimbursed only in emergency situations.

[3] Defendant note that non-contract hospitals may also receive supplemental MediCal reimbursements under programs such as the disproportionate share hospital (DSH) program, the

(Continued on following page)

For outpatient services as opposed to inpatient services, hospitals are reimbursed at established rates set by the Department. Mot. at 4; 22 CCR § 51509. For DP/NF's, Medi-Cal reimbursement is determined by a prospectively established per diem reimbursement rate for daily services, which is the lesser of a facility's projected costs or a prospectively determined median per diem rate. Mot. at 4; 22 CCR § 51511(a)(2). For subacute services, facilities are reimbursed per diem at a rate equal to the lesser of the facility's per day costs as projected by the Department or the class median per diem rate established by the Department. Mot. at 5; 22 CCR § 51511.5(a)(1).

For inpatient services at non-contract hospitals, AB 1183 amends Cal. Welf. & Inst. Code § 14166.245 to retain AB 5's ten percent reduction to both interim and final payment rates, and to mandate that such reimbursement be limited to "the applicable regional per diem contract rate for tertiary hospitals and for all other hospitals . . . Reduced by 5%, multiplied by the number of Medi-Cal covered inpatient days . . . ["the CMAC limit"]" Cal. Welf. & Inst. Code 14166.245(b)(2)(A), (c)(3)(B).[4] For DP/NF and subacute services, AB 1183 mandates a five percent reduction (from pre-AB 5 rates) in reimbursement rates. Cal.

Safety Net Care Pool (SNCP) program, and the Health Care Coverage Initiative (HCCI) program. Opp'n at 8; Amended Department Inpatient Analysis at 12.

[4] Certain hospitals, including small and rural hospitals, are exempt.

Welf. & Inst. Code § 14105.191. AB 1183 also mandates a one percent reimbursement rate reduction (from pre-AB 5 rates) for outpatient services. Cal. Welf. & Inst. Code § 14105.191.

III. LEGAL STANDARD

A preliminary injunction is appropriate when the moving party shows either (1) a combination of probable success on the merits and the possibility of irreparable harm, or (2) the existence of serious questions going to the merits and that the balance of hardships tips sharply in the moving party's favor. *See Rodeo Collection, Ltd. v. West Seventh,* 812 F.2d 1215, 1217 (9th Cir. 1987). These are not two distinct tests, but rather "the opposite ends of a single 'continuum in which the required showing of harm varies inversely with the required showing of meritoriousness.'" *Id.* A "serious question" is one on which the movant "has a fair chance of success on the merits." *Sierra On-Line, Inc. v. Phoenix Software, Inc.*, 739 F.2d 1415, 1421 (9th Cir. 1984).

IV. DISCUSSION

A. LIKELIHOOD OF SUCCESS ON THE MERITS

Pursuant to the holding of the Ninth Circuit in the related action *Independent Living,* 543 F.3d at 1065, the Court finds, as an initial matter, that plaintiffs may pursue a claim for relief under the Supremacy Clause based on the allegation that AB

1183 is preempted by § 30(A). Here, plaintiffs' Supremacy Clause claim is predicated upon federal conflict preemption. Under general principles of federal preemption, state law is preempted only to the extent that it actually conflicts with federal law. *Pacific Gas & Elec. Co. v. State Energy Comm'n*, 461 U.S. 190, 204 (1983). Such a conflict may arise either where "compliance with both federal and state regulations is a physical impossibility, or where state law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." *Id.* at 203-04 (citations omitted).

Thus, to prevail on the merits plaintiffs will have to prove either that it is not possible for the Department to comply with both AB 1183 and the Medicaid Act or that AB 1183 stands as an obstacle to the enforcement of § 30(A). As such, the Court turns to the statutory provisions at issue here.

The "quality of care" provision of § (30)(A) provides that:

> [a] State plan for medical assistance must . . . provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care.

42 U.S.C. § 1396a(30)(A). The "equal access" provision of § 30(A) provides that:

> [a] State plan for medical assistance must . . . provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are . . . sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

Id.

In *Orthopaedic Hospital v. Kizer*, 1992 WL 345652 (C.D. Cal. 1992) ("*Orthopaedic I*"), plaintiff-hospital providers filed suit pursuant to 42 U.S.C. § 1983 ("§ 1983"), claiming that the Director violated § 30(A) by setting reimbursement rates for hospital outpatient services without considering the effect of hospital costs on efficiency, economy, and quality of care.[5] *Id.* at *1. The district court concluded that § 30(A) was enforceable in a § 1983 action, and that the Department "had a judicially enforceable obligation" to consider and make findings each time it

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[5] The hospitals did not, however, challenge the rates under the "equal access" provision. *Orthopaedic I*, 1992 WL 345652 at *14 n.4.

modified reimbursement rates. *Id.* at *2. According to the district court, § 30(A) obligated the Department to consider efficiency, economy, and quality of care, which it referred to as the "relevant factors." *Id.* at *4. The district court found that the Director had acted arbitrarily and capriciously in establishing six of the seven challenged rates. *Id.* The court then remanded the matter to the Department for further consideration. *Id.* at *14. Upon remand, the Department conducted a rate study, and readopted the reimbursement rates without change. *Orthopaedic Hospital II/III,* 103 F.3d 1491, 1495 (9th Cir. 1997).

The hospitals returned to the district court, filing two lawsuits (*Orthopaedic II/III*) that the district court consolidated, arguing that the adopted rates did not comply with § 30(A). *Id.* The district court entered judgment in favor of the Department, finding that the Department was not statutorily required to consider hospital costs when setting reimbursement rates. *Id.* The hospitals appealed, and the Ninth Circuit reversed. The Ninth Circuit's interpretation held that § 30(A) "provides that payments for services must be consistent with efficiency, economy, and quality of care, and that those *payments* must be sufficient to enlist enough providers to provide access to Medicaid recipients." *Id.* at 1496 (emphasis in original). The Ninth Circuit therefore concluded that under § 30(A)

> the Director must set hospital outpatient reimbursement rates that bear a reasonable relationship to efficient and economical hospitals' costs of providing quality services,

> unless the Department shows some justification for rates that substantially deviate from such costs. To do this, the Department must rely on responsible cost studies, its own or others', that provide reliable data as a basis for its rate setting.

Id.[6] Further, the Ninth Circuit found that "[i]t is not justifiable for the Department to reimburse providers substantially less than their costs for purely budgetary reasons." *Id.* at 1499 n.3.[7]

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[6] *See e.g., Alaska Dep't of Health & Soc. Servs. v. Ctrs. for Medicare & Medicaid Servs.*, 424 F.3d 931, 940-41 (9th Cir. 2005); *see also Arkansas Med. Soc'y v. Reynolds*, 6 F.3d 519, 530 (8th Cir. 1993) ("We agree with the trial court's conclusion that the relevant factors that DHS is obliged to consider in its rate-making decisions are the factors outlined in 42 U.S.C. § 1396a(a)(30)(A)."); *cf. Methodist Hosps. v. Sullivan*, 91 F.3d 1026, 1030 (7th Cir. 1996) (finding that § 30(A) does not require a state to consider any particular factors, but rather, requires that the state arrive at substantive results consistent with the Medicaid Act); *Rite Aid, Inc. v. Houstoun*, 171 F.3d 842 (3d Cir. 1999) (same).

[7] Subsequently, in *Sanchez v. Johnson*, 416 F.3d 1051 (9th Cir. 2005), the Ninth Circuit held that § 30(A) does not confer individual rights that are enforceable under 42 U.S.C. § 1983. *Id.* at 1060. However, in *Independent Living*, 543 F.3d 1050 (9th Cir. 2008), the Ninth Circuit held that "a plaintiff seeking injunctive relief under the Supremacy Clause on the basis of federal preemption need not assert a federally created 'right,' in the sense that term has been recently used in suits brought under § 1983, but need only satisfy traditional standing requirements." *Independent Living*, 543 F.3d 1050, 1058 (9th Cir. 2008).

Whatever else its effect may have been, it is clear that *Sanchez v. Johnson*, 416 F.3d 1051 (9th Cir. 2005) left undisturbed the rule announced in *Orthopaedic II/III* that § 30(A) creates duties on behalf of the Department, i.e., the duty to consider efficiency, economy, and quality of care when establishing reimbursement rates. Indeed, the *Sanchez* court recognized that "[§ 30(A)] speaks . . . of the *State's obligation* to develop 'methods and procedures' for providing services generally." *Sanchez*, 416 F.3d at 1059 (emphasis added).

Because *Orthopaedic II/III* is binding authority on this Court, the Court finds that when the State of California seeks to modify reimbursement rates for health care services provided under the Medi-Cal program, it must consider efficiency, economy, and quality of care, as well as the effect of providers' costs on those relevant statutory factors.

In the instant motion for preliminary injunction, plaintiffs argue that AB 1183's rate reductions to hospitals is preempted by § 30(A), because the Legislature did not consider any of the relevant factors as required by *Orthopaedic II/III*. Specifically, plaintiffs argue that the legislative history indicates that "the California Legislature did not undertake studies of hospital costs prior to enacting AB 1183, or give any consideration to whether the payment rates which would be in effect under the application of the AB 1183 Hospital Rate Cuts would be reasonably related to hospital costs." Mot. at 13. Furthermore, plaintiffs argue that the language of AB 1183 itself

indicates that it was passed purely for budgetary reasons. For example, Cal. Welf. & Ins. [sic] Code § 14166.245, the provision implementing reductions to inpatient hospital services, states

> The Legislature finds and declares that the state faces a fiscal crisis that requires unprecedented measures to be taken to reduce General Fund expenditures to avoid reducing vital government services necessary for the protection of the health, safety, and welfare of the citizens of the State of California.

Defendants, however, argue that the requirements of *Orthopaedic II/III* are in fact satisfied, because the Department itself performed a detailed analysis of the relevant factors. Specifically, defendant argues that beginning in October 2008 and continuing into February 2009, the Department conducted formal written analyses of reimbursement under AB 1183 for non-contract hospital inpatient services, DP/NF, and subacute services, which are contained in the reports entitled "[Amended] Analysis of the Impact of Welfare and Institutions Code Section 14166.245 Concerning Medi-Cal Reimbursement for Non-Contract Hospital Inpatient Services" ("Amended Department Inpatient Analysis") and "Analysis of Assembly Bill 1183 Medi-Cal Reimbursement For Various Nursing Facility Services" ("Department Nursing Analysis").

Plaintiffs, however, argue that the Department's post-hoc analysis does not satisfy the requirements of

Orthopaedic II/III. The Court agrees. First, the Court notes that AB 1183, as passed by the Legislature, does not provide the Department with any discretion to determine whether the five percent rate reduction should be implemented based on the Department's consideration of the relevant factors. *See* Cal. Welf. & Inst. Code. § 14105.191 ("Notwithstanding any other provision of law, or order to implement changes in the level of funding for health care services, the *director shall reduce* provider payments, as specified in this section . . . ") (emphasis added). In *Orthopaedic II/III*, in which rates set by the Department, rather than the Legislature, were at issue, the court stated that the "the Department must rely on responsible cost studies, its own or others', that provide reliable data *as a basis* for its rate setting." 103 F.3d at 1496 (emphasis added); *see also id.* at 1499-1500 ("Since the Department did not adequately consider hospitals' costs *when readopting its rates*, the Department's actions were arbitrary and capricious and contrary to law") (emphasis added). The *Orthopaedic II/III* holding therefore indicates that the body responsible for rate setting must consider the relevant factors contemporaneously with the adoption of the rates. Because the Department has no authority to alter the rate reduction imposed by the Legislature, the Department's post hoc analysis does not satisfy the requirements of *Orthopaedic II/III*.

Furthermore, in this case, it does not appear that the Legislature appropriately considered any of the relevant factors before passing AB 1183.[4] Defendant responds to plaintiffs' arguments that the Legislature did not perform the required analysis by submitting evidence indicating that (1) between May 2008 and September 2008, Department employees provided information to legislative staff members concerning the rate reductions; (2) in June 2008, the Subcommittee 3 Health Human Services, Labor, and Veterans Affairs Major Action Report included modifications and rejections of certain rate reductions proposed by the Administration; and (3) in July 2008, the Summary Overview Budget Conference Committee Report includes discussions of the rate reductions. *See* Trueworthy Decl. ¶ 5, Exs. A-E. However, none of this evidence demonstrates that the Legislature relied on responsible cost studies providing

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[4] Defendant argues that "the Legislature followed the advice of the Legislative Analyst Office's (LAO) report concerning the 2008-2009 Budget . . . While the LAO expressed concerns about reductions for physician services, the LAO stated that 'Hospitals and some other providers have received recent rate increases. In contrast to physicians, Medi-Cal adjusts on an annual basis the reimbursement rates for certain other providers.'" Opp'n at 1. While defendant is correct that the LAO report discussed the possible rate reduction for hospital services, and ultimately concluded that such reductions were advisable, defendant presents no evidence to indicate that the Legislature actually reviewed or considered the LAO's report in passing AB 1183.

reliable data in setting the rates. *See Orthopaedic Hospital II/III,* 103 F.3d at 1496.

Therefore, because it appears that the Legislature and the Department did not properly consider the relevant factors prior to passing the rate reductions in AB 1183, the Court finds that plaintiffs have a strong likelihood of success on the merits.[9]

B. IRREPARABLE HARM

The next question before this Court is whether plaintiffs have shown that Medi-Cal beneficiaries will be irreparably harmed if the rate reduction to hospitals is permitted to go into effect. First, plaintiffs argue that the rates under AB 1183 are not reasonably related to provider costs. Mot. at 11. With regard to inpatient services, plaintiffs' submit an analysis of the effect of the AB 1183 ten percent rate reduction, which finds that, under AB 1183, no non-contract hospital will receive more than 90 percent of costs for inpatient services, while one-third of the hospitals will receive less than 55 percent of their

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[9] Plaintiffs also argue that (1) AB 1183 is preempted by § 13(A) of the Medicaid Act, because the State failed to comply with that provision's notice-and-comment requirements, and (2) AB 1183 violates 42 C.F.R. §§ 430.12, 447.252, 447.256(a)(1) because it was implemented without approval from the Federal government. Because the Court finds herein that plaintiffs have established a strong likelihood of success in demonstrating that the AB 1183 rate reductions for hospitals are preempted by § 30(A), the Court need not reach these issues.

costs for inpatient services. Mot. at 11; Zaretsky Decl. Ex. D (Comparison of Medi-Cal Percentages of Costs Paid Under 2009 Payment Limit and Under Prior, Cost Reimbursement, System); Ex E (Frequency Distribution of the Medi-Cal Percentages of Cost Paid Under the 2008 Reimbursement Limit and Under the Cost Reimbursement System). By contrast, plaintiffs argue, prior to AB 5 and AB 1183, 87 of the 95 affected hospitals were reimbursed between 95 and 100 percent of their costs for inpatient services. *Id.* Furthermore, plaintiffs argue, the CMAC limit imposed by AB 1183 does not take into account variations among hospitals in their costs in setting reimbursement, and, therefore, the reimbursement rates do not take [sic] reflect the costs of the individual hospital. Mot. at 12-13.

With regard to DP/NF services, which are reimbursed based on the lower of the projected costs or a statewide "median" cost per diem, and are subject to a five percent rate reduction under AB 1183, plaintiffs argue that the median cost per diem excludes certain DP/NF's with high costs, and that, as a result, the median is artificially deflated. Plaintiffs argue that while before AB 5 and AB 1183, 84 percent of costs of DP/NF services were reimbursed, under AB 1183, only 79 percent of costs will be reimbursed, and many facilities will receive less than half of their costs. Mot. at 14; Zaretsky Decl. ¶ 23.

With regard to subacute services, which are also subject to a five percent rate reduction under AB 1183, plaintiffs argue that the percentage of reimbursed

costs will decrease from 98 percent (before AB 5 and AB 1183) to 93 percent of costs for non-ventilator service providers, and from 95 percent (before AB 5 and AB 1183) to 91 percent of costs for ventilator services providers. Zaretsky Decl. ¶ 25.

With regard to hospital outpatient services, which are subject to a one percent rate reduction under AB 1183, plaintiffs argue that reimbursement for costs will decrease from 43 percent of costs (before AB 5 and AB 1183) to 41 percent of costs. Mot. at 14; Zaretsky Decl. ¶ 21.

Plaintiffs next argue that these rate reductions will cause irreparable harm, in the form of reduced hospital services to Medi-Cal beneficiaries. Plaintiffs argue first that many hospitals have already eliminated services due to the AB 5 rate cuts, which has in turn impacted the availability of medical services in certain communities. Duaner Decl. ¶ 8; Jordan Decl. ¶ 6; Miller ¶ 4; DeNio ¶ 4. Plaintiffs argue that AB 1183 will render inevitable further reductions and elimination of some hospital services. McKague Decl. ¶ 6; Delmore Decl. ¶ 6; Riccioni ¶¶ 4-5. For example, plaintiffs argue that the rate cuts will likely result in the forced closure of (1) the emergency department at Central Valley General Hospital in Hanford, CA; (2) skilled nursing and subacute units at Sharp Coronado Hospital and Healthcare Center; and (3) the Diabetes Education Center and Children's Speciality Clinic at El Centro Regional Medical Center in El Centro California (forcing patients to travel two hours to San Diego to obtain these

services).[10] Mot. at 21-22; McKague Decl. ¶ 6; Hall Decl. ¶¶ 5-7; Farmer Decl. ¶¶ 7-8.

Defendant, however, argues that the showing of harm by plaintiffs is too speculative. With regard to inpatient services, defendant argues that the Amended Department Inpatient Analysis determined that Medi-Cal reimbursement for noncontract hospital inpatient services will compensate approximately 91 percent of hospitals' audited costs under AB 1183; if small and rural hospitals, which are exempt from the rate reduction, are excluded from the analysis, 86 percent of hospitals' audited costs will continue to be reimbursed under AB 1183. Opp'n at 9; Amended Department Inpatient Analysis at 13. With regard to DP/NF and subacute services, defendant argues that under AB 1183, DP/NF and subacute providers will be reimbursed within a "range of reasonableness" (i.e. 85-95 percent of costs), and that the Department Nursing Analysis indicates that there will be

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[10] Plaintiffs also argue that hospitals will suffer pecuniary harm, and that such harm is irreparable because retroactive monetary claims are barred by the Eleventh Amendment in this action. Mot. at 22, citing *Kansas Health Care Assoc. v. Kansas Dept. Of Social and Rehabilitation Svcs.*, 31 F.3d 1536, 1543 (10th Cir. 1994) (harm from inadequate Medicaid reimbursement rates would be irreparable because Eleventh Amendment bars retrospective monetary relief). However, the Court notes that in that case, the Court held "the Eleventh Amendment bar simply indicates irreparability, but does not, in itself, establish harm." *See id.*

sufficient access to these services.[11] Opp'n at 10-11; Yien Decl. ¶ 4, 8. In addition, defendant notes that the transition from AB 5 to AB 1183 will in fact increase by 5.5 percent the reimbursement for these types of services. Opp'n at 11; Yien Decl. ¶¶ 2-18. Similarly, with regard to outpatient services, defendant notes that under AB 5 there was a ten percent rate reduction in effect, which is decreased to one percent under AB 1183. Opp'n at 11.

Defendants also argue that plaintiffs' evidence does not take into account the fact that Medi-Cal pays substantial supplemental reimbursement to many non-contract hospitals, which is not affected by AB 1183. Opp'n at 14; Liu Decl. ¶ 18. In fact, defendant argues that several of the hospitals submitting declarations in support of the preliminary injunction receive substantial additional reimbursement under one of the supplemental reimbursement programs not impacted by AB 1183, and that, additionally, many of the hospitals submitting declarations are making large profits.[12] Hutchinson Decl. ¶¶ 1-18 (describing various supplemental reimbursement programs paying extra money to hospitals including some submitting

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[11] Plaintiffs argue that the disparity between plaintiffs' cost estimate (reimbursement at 79 percent of costs) and defendant's cost estimate is that defendant included in the analysis supplemental payments, which were only received by 13 of the 78 hospitals included in the analysis. Reply at 15-16.

[12] Plaintiffs, however, respond that many of the supplemental reimbursement programs provide funding for services to non-MediCal patients. Reply at 13.

declarations); Ong Decl. ¶ 17 (14 of 19 hospitals submitting declarations were profitable in fiscal year ending in 2007, having a collective net income of $181.3 million; five hospitals operating at a loss, with a collective net loss of $29.2 million). Furthermore, defendant notes that reimbursement for hospital outpatient services has significantly increased between 2001 to 2004 to 43 percent above the levels in effect three years earlier. Opp'n at 12; Machado Decl. ¶ 9.

The Court agrees with defendant that plaintiffs have failed to show that AB 1183 rate reductions to hospitals will result in irreparable harm so as to warrant the issuance of an injunction. First, the Court notes that the Legislative Analyst Office's Report on the 2008-09 budget specifically recommended that the Legislature accept the Governor's proposal to reduce Medi-Cal reimbursement rates to hospitals, and indeed suggested that the Legislature increase the proposed reductions for hospitals. Legislative Analyst's Office Report, 2008-09 Analysis ("LAO Report") at C-39. The LAO report concluded ("[w]e recommend the Legislature reject the Governor's proposal to reduce payments for all providers except hospitals . . . Our review indicates that hospitals have received significant rate increases relative to other provider types in recent years, and hospitals are generally among the most expensive settings to provide care"). LAO Report at C-39.

More importantly, there is evidence showing that approximately 90 percent of hospital inpatient services are provided by contract hospitals that are

not subject to the AB 1183 rate reductions, and that such hospitals are contractually obligated to provide inpatients services to all Medi-Cal beneficiaries for whom such services are medically necessary and covered by Medi-Cal. *See* Amended Department Inpatient Analysis at 14. Moreover, there is evidence that there are 87 Federally Qualified Health Centers ("FQHC's") and 284 Rural Health Clinics ("RHC's") throughout California that provide outpatient services, which are not subject to the AB 1183 rate reduction. Opp'n at 12; Shine Decl. ¶ 4. Therefore, although there may be certain limited exceptions, it appears unlikely that Medi-Cal beneficiaries will go without access to needed inpatient and outpatient services under the AB 1183 rate reductions. Furthermore, defendant has submitted evidence demonstrating that many of the hospitals submitting declarations were profitable in the fiscal year ending in 2007, indicating that these facilities are likely capable of continuing to provide services even with the rate reductions in effect. Ong Decl. ¶ 17. Based on the present record, this evidence presented is too speculative to support a finding of irreparable harm.[13]

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[13] Because the Court finds herein that plaintiffs have failed to show irreparable harm, the Court determines that, regardless of the Court's findings regarding the balance of hardships and the public interest, a preliminary injunction is not warranted.

V. CONCLUSION

For the foregoing reasons, the Court DENIES plaintiffs' motion for preliminary injunction with regard to AB 1183's reimbursement rate reduction to hospitals, without prejudice to its being renewed after the Ninth Circuit rules on the appeal in *Independent Living Center of Southern California, Inc. v. Sandra Shewry*, CV-08-3315-CAS.

IT IS SO ORDERED

Dated: March 9, 2009

/s/ Christina A. Snyder
CHRISTINA A. SNYDER
UNITED STATES
DISTRICT JUDGE

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA
WESTERN DIVISION

Managed Pharmacy Care, et al. Plaintiff(s), vs. David Maxwell Jolly Defendant(s).	)	Case No. CV 09-382 CAS (MANx) ORDER GRANTING PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION (Filed Feb. 27, 2009)

I. INTRODUCTION AND BACKGROUND

On September 16, 2008, the California Legislature passed Assembly Bill 1183 ("AB 1183"), which was subsequently signed by the Governor and filed with the Secretary of State on September 30, 2008. AB 1183 amends Cal. Welf. & Inst. Code. § 14105.19 and mandates that, effective March 1, 2009, Medi-Cal reimbursement payments to some fee-for-service providers will be reduced by one percent or five percent, depending on provider type. Particularly relevant to the instant action, AB 1183 enacts a modified Cal. Welf. Inst. Code § 14105.191(b)(3) so as to require that Medi-Cal fee-for-service payments to pharmacies be reduced by 5 percent.

These reductions mandated in AB 1183 replace the ten percent rate reduction put into place by Assembly Bill X3 5 ("AB 5"), which is scheduled to terminate on February 28, 2009. *See* Cal. Welf. & Inst.

Code § 14105.19(b)(1). AB 5 was passed by the California Legislature on February 16, 2008. On August 18, 2008, the ten percent rate reduction mandated by AB 5 was partially enjoined by this Court in a related action, *Independent Living Center of Southern California, Inc. v. Sandra Shewry,* CV-08-3315 CAS (MANx). In issuing the preliminary injunction, this Court found that petitioners had, *inter alia,* demonstrated a strong likelihood of success in showing that AB 5 was preempted by § 30(A) of the Medicaid Act (referred to herein as "§ 30(A)"). The Court's August 18, 2008 order is currently being appealed to the Court of Appeals for the Ninth Circuit.[1]

On January 16, 2009, Managed Pharmacy Care, Independent Living Center of Southern California, Inc., Gerald Shapiro, Sharon Steen, and Tran Pharmacy, Inc. filed the instant action against David Maxwell-Jolly, Director of the Department of Health Care Services of the State of California. Plaintiffs' complaint challenges the five percent Medi-Cal reimbursement rate reduction to providers of pharmacy

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[1] The Court's August 18, 2008 order was issued on remand from the Ninth Circuit, after plaintiffs appealed this Court's original June 25, 2008 ruling on their preliminary injunction motion. The Court's June 25, 2008 order found that plaintiffs in *Independent Living* lacked any federal rights under § 30(A), and therefore had denied petitioners' motion for preliminary injunction. On appeal, the Ninth Circuit held that plaintiffs could bring suit under the Supremacy Clause to enjoin AB 5 as preempted under the Medicaid Act, and remanded to this Court. *See Independent Living Center of Southern California et. al. v. Sandra Shewry et al.*, 543 F.3d 1050 (9th Cir. 2008).

services under AB 1183. Plaintiffs seek an order directing defendant "to set aside his preempted policy to implement § 14105.19 Welf. & Inst. Code, of AB 1183, and the 5% Rate Reduction, and, to refrain from implementing the same; including but not limited to refraining from reducing payments by five percent or by any other deduction, to pharmacy providers in the Medi-Cal FFS program, for services furnished on and after March 1, 2009."[2] Compl. at 8; Mot. at 1.

On February 2, 2009, plaintiffs filed the instant motion for a preliminary injunction. Defendant filed an opposition thereto on February 11, 2009. A reply was filed on February 16, 2009. Plaintiffs' motion for a preliminary injunction is currently before the Court.

II. LEGAL STANDARD

A preliminary injunction is appropriate when the moving party shows either (1) a combination of probable success on the merits and the possibility of irreparable harm, or (2) the existence of serious questions going to the merits and that the balance of hardships tips sharply in the moving party's favor. *See Rodeo Collection, Ltd. v. West Seventh*, 812 F.2d 1215, 1217 (9th Cir. 1987). These are not two distinct tests, but rather "the opposite ends of a single 'continuum in which the required showing of harm varies inversely with the required showing of meritoriousness.'" *Id.*

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[2] On January 26, 2009, plaintiff Managed Pharmacy Care was voluntarily dismissed as a plaintiff in this action.

A "serious question" is one on which the movant "has a fair chance of success on the merits." *Sierra On-Line, Inc. v. Phoenix Software, Inc.*, 739 F.2d 1415, 1421 (9th Cir. 1984).

III. DISCUSSION

A. ELEVENTH AMENDMENT AND PRUDENTIAL STANDING

Before addressing the merits of plaintiffs' argument for preliminary injunction, the Court must first address two arguments raised by defendant: (1) that plaintiffs' suit is barred by the Eleventh Amendment and (2) that plaintiffs lack standing. The Court finds that neither of these arguments is persuasive.

The essence of defendant's Eleventh Amendment argument is that plaintiffs' suit effectively amounts to a request for money damages to be paid out of the state treasury, in violation of the Eleventh Amendment. *See* Opp'n at 20 ("the primary purpose driving this lawsuit is to obtain funds from the State above the 5% payment reduction"), citing *Edelman v. Jordan*, 415 U.S. 651 ("Thus the rule has evolved that a suit by private parties seeking to impose a liability which must be paid from public funds in the state treasury is barred by the Eleventh Amendment"). However, the Court disagrees with defendant's characterization of plaintiffs' claim. Plaintiffs complaint does not seek money damages, but instead seeks only prospective injunctive relief – namely, an injunction preventing defendant from enforcing a state law that,

defendants argue, is preempted by the Medicaid Act. Such prospective injunctive relief against a state official is permissible under *Ex Parte Young*, 209 U.S. 123 (1908), even where such an injunction will have an effect on the state treasury. *See, e.g., Milliken v. Bradley*, 433 U.S. 267 (federal courts permitted "to enjoin state officials to conform their conduct to requirements of federal law, notwithstanding a direct and substantial impact on the state treasury").

Defendant also argues that plaintiffs lack prudential standing, because they are health care providers who have no "rights" under the federal law they seek to enforce. Opp'n at 22. The Court disagrees. In its September 17, 2008 order in the related action *Independent Living*, 543 F.3d at 1065, the Ninth Circuit determined that petitioners in that action had standing:

> Petitioners include independent pharmacies and health care providers participating in the State's Medi-Cal program that, according to their complaint, will be directly injured, by loss of gross income, when the ten-percent rate reduction takes effect. The Supreme Court repeatedly has recognized that such [direct economic] injuries establish the threshold requirements of Article III standing. Moreover, this injury is directly traceable to the Director's implementation of AB 5, and would certainly be redressed by a favorable decision of this court enjoining the ten-percent rate reduction.

As in *Independent Living*, plaintiffs in the instant action include independent pharmacies participating in the Medi-Cal program, and an independent living center which serves over 8,000 individuals with disabilities annually, 96 percent of whom are Medi-Cal beneficiaries, who, plaintiffs allege, would be directly injured by the five percent Medi-Cal reimbursement rate reduction. *See* Vescovo Decl. ¶ 5. Therefore, the Ninth Circuit's holding in *Independent Living*, 543 F.3d at 1065, with regard to standing applies in this case as well, and the Court finds defendant's argument that plaintiffs lack standing to be without merit.

B. LIKELIHOOD OF SUCCESS ON THE MERITS

Pursuant to the holding of the Ninth Circuit in the related action *Independent Living*, 543 F.3d at 1065, the Court finds, as an initial matter, that plaintiffs may pursue a claim for relief under the Supremacy Clause based on the allegation that AB 1183 is preempted by § 30(A). Here, plaintiffs' Supremacy Clause claim is predicated upon federal conflict preemption. Under general principles of federal preemption, state law is preempted only to the extent that it actually conflicts with federal law. *Pacific Gas & Elec. Co. v. State Energy Comm'n*, 461 U.S. 190, 204 (1983). Such a conflict may arise either where "compliance with both federal and state regulations is a physical impossibility, or where state law stands as an obstacle to the accomplishment and execution of

the full purposes and objectives of Congress." *Id.* at 203-04 (citations omitted).

Thus, to prevail on the merits plaintiffs will have to prove either that it is not possible for the Department to comply with both AB 1183 and the Medicaid Act or that AB 1183 stands as an obstacle to the enforcement of § 30(A). As such, the Court turns to the statutory provisions at issue here.

The "quality of care" provision of § (30)(A) provides that

> [a] State plan for medical assistance must . . . provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care.

42 U.S.C. § 1396a(a)(30)(A). The "equal access" provision of § 30(A) provides that

> [a] State plan for medical assistance must . . . provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are . . . sufficient to enlist enough providers so that care and services are available under the plan at least to the

> extent that such care and services are available to the general population in the geographic area.

Id.

In *Orthopaedic Hospital v. Kizer*, 1992 WL 345652 (C.D. Cal. 1992) ("*Orthopaedic I*"), plaintiff-hospital providers filed suit pursuant to 42 U.S.C. § 1983 ("§ 1983"), claiming that the Director violated § 30(A) by setting reimbursement rates for hospital outpatient services without considering the effect of hospital costs on efficiency, economy, and quality of care.[3] *Id.* at *1. The district court concluded that § 30(A) was enforceable in a § 1983 action, and that the Department "had a judicially enforceable obligation" to consider and make findings each time it modified reimbursement rates. *Id.* at *2. According to the district court, § 30(A) obligated the Department to consider efficiency, economy, and quality of care, which it referred to as the "relevant factors." *Id.* at *4. The district court found that the Director had acted arbitrarily and capriciously in establishing six of the seven challenged rates. *Id.* The court then remanded the matter to the Department for further consideration. *Id.* at *14. Upon remand, the Department conducted a rate study, and readopted the

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[3] The hospitals did not, however, challenge the rates under the "equal access" provision. *Orthopaedic I*, 1992 WL 345652 at *14 n.4.

reimbursement rates without change. *Orthopaedic Hospital*, 103 F.3d at 1495.

The hospitals returned to the district court, filing two lawsuits (*Orthopaedic II/III*) that the district court consolidated, arguing that the adopted rates did not comply with § 30(A). *Id.* The district court entered judgment in favor of the Department, finding that the Department was not statutorily required to consider hospital costs when setting reimbursement rates. *Id.* The hospitals appealed, and the Ninth Circuit reversed. The Ninth Circuit's interpretation held that § 30(A) "provides that payments for services must be consistent with efficiency, economy, and quality of care, and that those *payments* must be sufficient to enlist enough providers to provide access to Medicaid recipients." *Id.* at 1496 (emphasis in original). The Ninth Circuit therefore concluded that under § 30(A)

> the Director must set hospital outpatient reimbursement rates that bear a reasonable relationship to efficient and economical hospitals' costs of providing quality services, unless the Department shows some justification for rates that substantially deviate from such costs. To do this, the Department must rely on responsible cost studies, its own or others', that provide reliable data as a basis for its rate setting.

Id.[4] Further, the Ninth Circuit found that "[i]t is not justifiable for the Department to reimburse providers substantially less than their costs for purely budgetary reasons." *Id.* at 1499 n.3.[5]

Whatever else its effect may have been, it is clear that *Sanchez v. Johnson*, 416 F.3d 1051 (9th Cir. 2005) left undisturbed the rule announced in *Orthopaedic II/III* that § 30(A) creates duties on behalf of the Department, i.e., the duty to consider efficiency, economy, and quality of care when establishing reimbursement rates. Indeed, the *Sanchez* court recognized that "[§ 30(A)] speaks . . . of the

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[4] *See e.g., Alaska Dep't of Health & Soc. Servs. v. Ctrs. for Medicare & Medicaid Servs.*, 424 F.3d 931, 940-41 (9th Cir. 2005); *see also Arkansas Med. Soc'y v. Reynolds*, 6 F.3d 519, 530 (8th Cir. 1993) ("We agree with the trial court's conclusion that the relevant factors that DHS is obliged to consider in its rate-making decisions are the factors outlined in 42 U.S.C. § 1396a(a)(30)(A)."); *cf. Methodist Hosps. v. Sullivan*, 91 F.3d 1026, 1030 (7th Cir. 1996) (finding that § 30(A) does not require a state to consider any particular factors, but rather, requires that the state arrive at substantive results consistent with the Medicaid Act); *Rite Aid, Inc. v. Houstoun*, 171 F.3d 842 (3d Cir. 1999) (same).

[5] Subsequently, in *Sanchez v. Johnson*, 416 F.3d 1051 (9th Cir. 2005), the Ninth Circuit held that § 30(A) does not confer individual rights that are enforceable under 42 U.S.C. § 1983. *Id.* at 1060. However, in *Independent Living*, 543 F.3d 1050 (9th Cir. 2008), the Ninth Circuit held that "a plaintiff seeking injunctive relief under the Supremacy Clause on the basis of federal preemption need not assert a federally created 'right,' in the sense that term has been recently used in suits brought under § 1983, but need only satisfy traditional standing requirements." *Independent Living*, 543 F.3d 1050, 1058 (9th Cir. 2008).

State's obligation to develop 'methods and procedures' for providing services generally."[6] *Sanchez*, 416 F.3d at 1059 (emphasis added).

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[6] Defendant nevertheless argues herein that under *Sanchez v. Johnson*, 416 F.3d 1051, plaintiffs are precluded from obtaining a judicial remedy, and that "Plaintiffs are attempting to have this Court undercut decades of federal jurisprudence to say that, merely by claiming to be suing under the Supremacy Clause instead of § 1983, a party can obtain a remedy in federal court against a state agency for non-compliance with a provision of the Medicaid Act . . . " Opp'n at 18. Defendant argues that the Ninth Circuit's holding in *Independent Living*, 543 F.3d 1050, does not contradict this argument, because the issue presented herein is substantially different from the issue presented in that case. Opp'n at 16 ("the only issue in front of the Court of Appeals in the *Independent Living Center* matter was 'whether ILC may maintain a valid cause of action to enjoin implementation of AB 5 on the basis of federal preemption"). However, the Court finds defendant's arguments unpersuasive. The Court disagrees that the issue presented herein is substantially different from the issue before the Ninth Circuit in *Independent Living*, 543 F.3d at 1063, and further notes that the Ninth Circuit in *Independent Living* specifically distinguished *Sanchez*:

> [In *Sanchez*] [w]e held that the quality of care and access provisions of § 30(A) do not give rise to the type of unambiguously conferred rights required under Gonzaga. But our decision in [*Sanchez*] had nothing to say about a claim for injunctive relief brought under the Supremacy Clause. Indeed, even as the Supreme Court has tightened the requirements for seeking damages under § 1983, it has consistently reaffirmed the availability of injunctive relief to prevent state officials from implementing state legislation allegedly preempted by federal law.

Defendant also argues herein that Congress has evinced an intent that § (30)(a) not be judicially enforced. Opp'n at 17, n.8. Specifically, defendant notes that the so-called "Boren

(Continued on following page)

Because *Orthopaedic II/III* is binding authority on this Court, the Court finds that when the State of California seeks to modify reimbursement rates for health care services provided under the Medi-Cal program, it must consider efficiency, economy, and quality of care, as well as the effect of providers' costs on those relevant statutory factors.

In the instant motion for preliminary injunction, plaintiffs argue that AB 1183's five percent

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Amendment," which required that states provide the Secretary with assurances that Medicaid reimbursements according to rates that were "reasonable and adequate" to meet costs, was repealed by Congress subsequent to a Supreme Court decision finding that providers had rights under the Boren Amendment to challenge the adequacy of a state's reimbursement rates under the Medicaid statute. Opp'n at 5. However, defendant's arguments are belied by *Orthopaedic II/III*, which held that the Department's obligations under § 30(a) were independent of the obligations imposed by the Boren Amendment:

> The Boren Amendment requires the Department to make assurances to the Secretary of Health and Human Services that rates are reasonable and adequate to meet the hospitals' costs, and requires periodic cost reports from hospitals subject to audit by the Department. These requirements are not part of § 1396a(a)(30)(A). The requirements of § 1396a(a)(30)(A) are more flexible than the Boren Amendment, but not so flexible as to allow the Department to ignore the costs of providing services. For payment rates to be consistent with efficiency, economy, quality of care and access, they must bear a reasonable relationship to provider costs, unless there is some justification for rates that do not substantially reimburse providers their costs.

Orthopaedic II/III, 103 F.3d at 1499.

reimbursement rate reduction to pharmacies is preempted by § 30(A), because the Legislature did not consider any of the relevant factors as required by *Orthopaedic II/III*. To demonstrate that the Legislature did not consider any of the relevant factors, plaintiffs first note that Sec. 76 of AB 1183 indicates that the purpose of the bill was budgetary:

> [t]his act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are: In order to make the necessary statutory changes to implement the Budget Act of 2008 at the earliest possible time, it is necessary that this act take effect immediately.

Plaintiffs further describe the legislative history of AB 1183, which, they argue, demonstrates that the Legislature did not consider any of the relevant factors:

> AB 1183 was introduced Feb. 2, 2008 as a hazardous material bill and was amended several times as solely a hazardous material bill. However, on September 15, 2008, the bill was amended in the Senate so as to be at once turned into a trailer bill, on many different subjects . . . All without any public hearings or any hearing by any committee of the Legislature; was passed shortly before midnight of the same day of September 15, 2008 by the Senate; was sent to the

> Assembly, and was immediately passed by the Assembly before 2:08 a.m. of September 16, 2008, – all within the space of a few hours . . .

Mot. at 8.

Defendant does not appear to contest that the Legislature did not in fact consider the relevant factors prior to passing AB 1183. However, defendant appears to argue that the requirements of *Orthopaedic II/III* are nevertheless satisfied, because the Department itself performed a detailed analysis of the relevant factors. Opp'n at 11. Specifically, defendant submits the Department's report "Analysis of Pharmacy Reimbursement under AB 1183," ("Department Analysis") completed in February 2009, well after the enactment of AB 1183 on September 16, 2008. Opp'n at 11. The Department Analysis analyzes the impact of the five percent rate reduction, and ultimately concludes:

> After a 5% payment reduction is implemented on March 1, 2009, Medi-Cal reimbursement paid to pharmacies will comply with title 42, United States Code, section 1396(a)(30)(A). The available data indicates that Medi-Cal recipients will continue to have sufficient access to pharmacy services as required by federal law. Reimbursement will be below applicable federal upper payment limits. The 5% payment reduction will result in more efficient and economical Medi-Cal coverage. It will not have any negative impact for Medi-Cal recipients. Finally, the Department

> determined that Medi-Cal reimbursement will in the aggregate compensate pharmacy drug costs at a level that is well above the "range of reasonableness" that was acceptable under the repealed Boren Amendment. Thus, reimbursement will be sufficient under the more flexible requirements of section 1396(a)(30)(A).

Def's Ex. A-A (Analysis of Assembly Bill 1183 Medi-Cal Reimbursement for Pharmacies) at 12-13. The Department Analysis further concludes that the Legislature "had other alternatives for reducing spending in the Medi-Cal program, which would have had a much more negative impact on Medi-Cal recipients. Def's Ex. A-A (Analysis of Assembly Bill 1183 Medi-Cal Reimbursement for Pharmacies) at 4.

Plaintiffs, however, argue that the Department's post-hoc analysis does not satisfy the requirements of *Orthopaedic II/III*. The Court agrees. First, the Court notes that AB 1183, as passed by the Legislature, does not provide the Department with any discretion to determine whether the five percent rate reduction should be implemented based on the Department's consideration of the relevant factors. *See* Mot. at 5-6; Cal. Welf. & Inst. Code. § 14105.191 ("Notwithstanding any other provision of law, or order to implement changes in the level of funding for health care services, the *director shall reduce* provider payments, as specified in this section . . . ") (emphasis added). In *Orthopaedic II/III*, in which rates set by the Department, rather than the Legislature, were at issue, the

court stated that the "the Department must rely on responsible cost studies, its own or others', that provide reliable data *as a basis* for its rate setting." 103 F.3d at 1496 (emphasis added); *see also id.* at 1499-1500 ("Since the Department did not adequately consider hospitals' costs *when readopting its rates*, the Department's actions were arbitrary and capricious and contrary to law") (emphasis added). The *Orthopaedic II/III* holding therefore indicates that the body responsible for rate setting must consider the relevant factors contemporaneously with the adoption of the rates. Here, the legislative history shows no indication that the Legislature considered any of the relevant factors before implementing AB 1183. Instead, it appears that the Legislature enacted the rate reduction purely for budgetary reasons. Because the Department has no authority to alter the rate reduction imposed by the Legislature, the Department's post hoc analysis does not satisfy the requirements of *Orthopaedic II/III*.

Therefore, because the Legislature did not consider any of the relevant factors prior to implementing the five percent rate reduction in AB 1183, the Court finds that plaintiffs have a strong likelihood of success on the merits.

C. IRREPARABLE HARM

The next question before this Court is whether plaintiffs have shown that Medi-Cal beneficiaries will be irreparably harmed if the five percent rate

reduction to pharmacies is permitted to go into effect. After reviewing the declarations submitted by plaintiffs and defendant, the Court finds that plaintiffs have made a sufficient showing of irreparable harm to warrant an injunction.

Plaintiffs submit the declaration of Richard Wilson, a Certified Public Accountant who has examined various data regarding Medi-Cal prescription drug reimbursement – including the Survey of Dispensing and Acquisition Costs of Pharmaceuticals in the State of California, a December 2007 study prepared by Myers and Stauffer, CPA's ("Myers Stauffer study") – in order to examine the impact of the five percent rate reduction on pharmacies.

Wilson notes that there are two primary cost components in the provision of prescription drugs: dispensing cost and drug acquisition cost. Wilson states that the average cost to a pharmacy for dispensing a prescription is currently $11.49 per prescription, and that the five percent reimbursement rate reduction will reduce Medi-Cal coverage for pharmacies' dispensing fees, from an average of $7.25 per prescription to an average of $6.88 per prescription. Wilson Decl. ¶ 21-22. Wilson states that the five percent reduction will therefore increase the loss incurred by pharmacies on dispensing fees from $3.56 per Medi-Cal prescription to $4.61 per Medi-Cal prescription. Wilson Decl. ¶ 22.

Furthermore, Wilson, states that the five percent rate reduction will also cause pharmacies to

experience a loss on the acquisition of many brand and generic drugs. For example, Wilson states that the average acquisition costs for brand drugs is 79 percent of average wholesale price, while the amount of reimbursement that pharmacies will receive under the five percent rate reduction is only 78.85 percent of average wholesale price. Wilson Decl. ¶ 24. As a result, Wilson states that the five percent rate reduction will cause pharmacies to operate at a loss in the acquisition of 51 percent of the 200 top-selling brand drugs, and that pharmacies will make only a very small gross profit on an additional 12.5 percent of the top-selling brand drugs, a profit which will generally be insufficient to compensate for the loss that the pharmacies incur in dispensing costs. Wilson Decl. ¶ 25. With regard to generic drugs, Wilson states that the five percent rate reduction will cause pharmacies to operate at a loss or obtain only a very small gross profit on 39 percent of the top-selling generic drugs. Wilson Decl. ¶ 31.

Wilson concludes that because pharmacies, on average, will suffer a financial loss to acquire and dispense brand drugs as a result of the five percent rate reduction, many will be forced to stop dispensing many if not most brand products to Medi-Cal patients. Wilson Decl. ¶ 28. Wilson further concludes that, as a result of the five percent rate reduction, many pharmacies will also be forced to stop dispensing many of the generic drugs to Medi-Cal patients. Wilson Decl. ¶ 32.

Petitioners also submit additional declarations providing further evidence to the effect that the five percent rate reduction will cause independent pharmacy owners to limit the scope of the services they provide to Medi-Cal beneficiaries. Specifically, plaintiffs submit the declarations of ten independent pharmacists, many of whom state that the five percent rate reduction will significantly affect their ability to provide services to Medi-Cal patients. *See* Davis Decl. ¶ 8; Dunckel Decl. ¶ 8; Faast Decl. ¶ 8. For example, the pharmacists' declarations state that the total reimbursement under AB 1183 will cover neither their acquisition costs nor their dispensing costs on many drugs, and that, as a result, they will not be able to fill all Medi-Cal prescriptions, including some prescriptions for AIDS medications and name-brand antipsychotropics, and will not be able to serve all existing Medi-Cal customers. *See* Davis Decl. ¶ 8, 11; Dunckel Decl. ¶ 8, 11; Faast Decl. ¶ 11; Shapiro Decl. ¶ 26; Tran Decl. ¶ 17; Medina Decl. ¶ 11; Tran Decl. ¶ 20. Some of the pharmacists also state that the five percent rate reduction will prevent them from accepting new Medi-Cal patients. *See* Dunckel Decl. ¶ 11; Jeha Decl. ¶ 11. In addition, some pharmacists say they will be forced to cut the business hours of the pharmacy and lay off employees in order to remain profitable, while others state that the five percent rate reduction will force them out of business. *See, e.g.*, Jeha Decl. ¶ 11; Leonelli Decl. ¶ 11. Some pharmacists state that the five percent rate reduction will prevent them from providing prescription delivery service to their Medi-Cal beneficiary patients who

are unable to leave their homes. *See* Medina Decl. ¶ 9; Shapiro Decl. ¶ 26.

Defendant counters that plaintiffs' showing of harm is speculative and that, in fact, under the five percent rate reduction, "an extremely high percentage of pharmacy costs will be compensated and the more efficient pharmacies should be able to obtain a substantial profit from providing services under the Medi-Cal program." Opp'n at 5. For example, defendant notes that the Department Analysis estimates that under the five percent rate reduction, pharmacies will continue, on average, to be compensated above their costs for Medi-Cal prescriptions. *See* Def's Ex. A-A at 8 (stating that the five percent rate reduction will reduce the aggregate Medi-Cal reimbursement for prescription drugs from compensating approximately 108.7 percent of pharmacy costs to approximately 103 percent of pharmacy costs).

Defendant also submits the declaration of Kevin Gorospe, who is employed as the Department's Chief of Medi-Cal Pharmacy Policy Branch. Gorospe states that he has examined plaintiffs' submitted declarations, and has calculated that, with one exception, the total revenue loss after the five percent rate reduction for each pharmacist submitting a declaration in support of plaintiffs' motion will be less than 2 percent. Gorospe Decl. ¶ 12. Gorospe further argues that some of plaintiffs' cost estimates are misleading, because much of the average dispensing fee costs are costs of operation that a pharmacy incurs regardless of whether it provides drugs to Medi-Cal recipients, so

that "continued participation in Medi-Cal by these pharmacies brings in additional reimbursement that will help to pay for many of the costs of operating a pharmacy that the pharmacy would incur even if [it] didn't participate in Medi-Cal." Gorospe Decl. ¶ 13. Gorospe further echoes the Department Analysis, stating that dispensing cost increases will not cause irreparable harm, because "Medi-Cal reimbursement for the drug itself frequently is well above pharmacy acquisition cost, that any loss on the dispensing fee portion of reimbursement is made up for by a significant profit on MediCal reimbursement for the drug itself." Gorospe Decl. ¶ 21.

The Court concludes that defendant has failed to refute plaintiffs' showing of irreparable harm. Even if defendant is correct that, on average, pharmacies will be compensated above their acquisition costs even after the five percent rate reduction, defendant has not refuted plaintiffs' findings that many brand and generic drugs will be reimbursed at a level below cost, thereby preventing pharmacies from providing those drugs and limiting access for Medi-Cal patients. Indeed, the Gorospe declaration confirms that only 98-99 percent, on average, of pharmacy costs for single source drugs will be compensated after the five percent rate reduction. Because many single source drugs are protected from competition by patents, there are no available generic alternatives. *See* August 18, 2008 Preliminary Injunction Order. There can be little or no doubt that Medi-Cal patients will

be harmed if these necessary drugs are placed outside of their reach.

Furthermore, if pharmacists are forced to curtail services or go out of business, there is no indication that all existing customers will have access to other pharmacies in which to obtain their medication and, in some cases, home-delivery services for such medication. Indeed, the many declarations submitted by petitioners show that independent pharmacy providers, who constitute approximately thirty-three percent of the licensed community pharmacies in California, will be hard-hit by the five percent rate reduction, and may discontinue, or at least severely reduce, services to Medi-Cal beneficiaries. *See* August 18, 2008 Preliminary Injunction Order. Therefore, the Court concludes that plaintiffs have demonstrates [sic] a significant likelihood of irreparable harm.

D. BALANCE OF HARDSHIPS

The Court is mindful of the difficulty facing the State of California in light of its fiscal crisis.[7] However, the State has accepted federal funds under the Medicaid Act. In so doing, the State agreed to abide by the conditions imposed by Congress. Further,

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[7] The Court notes that there is evidence to suggest that if the five percent rate reduction is given effect, many Medi-Cal beneficiaries will turn to more costly forms of medical care, such as emergency room care, thereby diminishing the State's projected savings. *See e.g., Rodde v. Bonta*, 357 F.3d 988, 999 (9th Cir. 2004).

retroactive relief for Medi-Cal beneficiaries will likely be inadequate and, and [sic] it will come too late, to remedy their pain, suffering, and harm to their mental and physical well-being. *See e.g., Lopez v. Heckler,* 713 F.2d 1432, 1437 (9th Cir. 1983). In light of the significant threat to the health of Medi-Cal recipients, reducing payments to health-care service providers will likely cause, and given that nothing in this Court's order prevents respondent from imposing a rate reduction after she has appropriately considered and applied the relevant factors, the Court finds that the balance of hardships tips in favor of granting the preliminary injunction.

E. PUBLIC INTEREST

"The district court's public interest analysis should be whether there exists some critical public interest that would be injured by the grant of preliminary relief." *Hybritech,* 849 F.2d at 1458. Clearly, there is a public interest in ensuring that the State has enough money to meet its financial obligations in the face of competing demands. However, there is also a public interest in ensuring access to health care. In light of all the circumstances, including the fact that the State may decide to implement a rate change upon making a properly reasoned and supported analysis, the Court finds that the public interest does not weigh against the issuance of a preliminary injunction.

IV. CONCLUSION

For the foregoing reasons, the Court GRANTS plaintiffs' motion for preliminary injunction. The Court hereby orders respondent Director, his agents, servants, employees, attorneys, successors, and all those working in concert with him to refrain from enforcing Cal. Welf. & Inst. Code § 14105.191(b)(3), as modified by AB 1183 beginning on March 1, 2009, by refraining from reducing by five percent payments to pharmacies for prescription drugs (including prescription drugs and traditional over-the-counter drugs provided by prescription) provided under the Medi-Cal fee-for-service program.[8]

Dated: February 27, 2009

/s/ Christina A. Snyder
CHRISTINA A. SNYDER
UNITED STATES
DISTRICT JUDGE

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[8] Plaintiff's motion appears to seek an injunction as to the five percent rate reduction for all pharmacy products, not just drugs. However, plaintiffs' arguments regarding irreparable harm focus on brand and generic drugs dispensed by pharmacies; plaintiffs have not shown irreparable harm as to the effect of the five percent rate reduction on other pharmacy products. Therefore, the Court limits the scope of the injunction to drug products dispensed by pharmacies.

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA

CIVIL MINUTES –GENERAL

Case No. CV 09-382 CAS (MANx) Date April 3, 2009

Title Managed Pharmacy Care et al v. David Maxwell-Jolly

Present: The Honorable CHRISTINA A. SNYDER

Catherine Jeang	Not Present	N/A
Deputy Clerk	Court Reporter/ Recorder	Tape No.

Attorneys Present for Plaintiffs:	Attorneys Present for Defendants:
Not Present	Not Present

Proceedings: (In Chambers:) Defendant's Motion to Alter or Amend, and Clarify the Court's February 27, 2009 (filed 3/13/2009)

The Court finds this motion appropriate for decision without oral argument. Fed. R. Civ. P. 78; Local Rule 7-15. Accordingly, the hearing date of April 6, 2009, is hereby vacated, and the matter is hereby taken under submission.

I. INTRODUCTION AND BACKGROUND

On September 16, 2008, the California Legislature passed Assembly Bill 1183 ("AB 1183"), which was subsequently signed by the Governor and filed

with the Secretary of State on September 30, 2008. AB 1183 amends Cal. Welf. & Inst. Code. § 14105.19 and mandates that, effective March 1, 2009, Medi-Cal reimbursement payments to some fee-for-service providers will be reduced by one percent or five percent, depending on provider type. Particularly relevant to the instant action, AB 1183 enacts a modified Cal. Welf. Inst. Code § 14105.191(b)(3) so as to require that Medi-Cal fee-for-service payments to pharmacies be reduced by 5 percent.

These reductions mandated in AB 1183 replace the ten percent rate reduction put into place by Assembly Bill X3 5 ("AB 5"), which is scheduled to terminate on February 28, 2009. *See* Cal. Welf. & Inst. Code § 14105.19(b)(1). AB 5 was passed by the California Legislature on February 16, 2008. On August 18, 2008, the ten percent rate reduction mandated by AB 5 was partially enjoined by this Court in a related action, *Independent Living Center of Southern California, Inc. v. Sandra Shewry*, CV-08-3315 CAS (MANx). In issuing the preliminary injunction, this Court found that petitioners had, *inter alia*, demonstrated a strong likelihood of success in showing that AB 5 was preempted by § 30(A) of the Medicaid Act (referred to herein as " § 30(A)"). The Court's August 18, 2008 order is currently being appealed to the Court of Appeals for the Ninth Circuit.[1]

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[1] The Court's August 18, 2008 order was issued on remand from the Ninth Circuit, after plaintiffs appealed this Court's

(Continued on following page)

On January 16, 2009, Managed Pharmacy Care, Independent Living Center of Southern California, Inc., Gerald Shapiro, Sharon Steen, and Tran Pharmacy, Inc. filed the instant action against David Maxwell-Jolly, Director of the Department of Health Care Services of the State of California. Plaintiffs' complaint challenged the five percent Medi-Cal reimbursement rate reduction to providers of pharmacy services under AB 1183. Plaintiffs sought an order directing defendant "to set aside his preempted policy to implement § 14105.19 Welf. & Inst. Code, of AB 1183, and the 5% Rate Reduction, and, to refrain from implementing the same; including but not limited to refraining from reducing payments by five percent or by any other deduction, to pharmacy providers in the Medi-Cal FFS program, for services furnished on and after March 1, 2009."[2] Compl. at 8; Mot. at 1.

On February 2, 2009, plaintiffs filed a motion for a preliminary injunction. On February 27, 2009, the Court granted plaintiffs' motion for preliminary

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original June 25, 2008 ruling on their preliminary injunction motion. The Court's June 25, 2008 order found that plaintiffs in *Independent Living* lacked any federal rights under § 30(A), and therefore had denied petitioners' motion for preliminary injunction. On appeal, the Ninth Circuit held that plaintiffs could bring suit under the Supremacy Clause to enjoin AB 5 as preempted under the Medicaid Act, and remanded to this Court. *See Independent Living Center of Southern California et. al. v. Sandra Shewry et al.*, 543 F.3d 1050 (9th Cir. 2008).

[2] On January 26, 2009, plaintiff Managed Pharmacy Care was voluntarily dismissed as a plaintiff in this action.

injunction and ordered the Department to refrain from reducing by five percent payments to pharmacies for prescription drugs provided under the Medi-Cal fee-for-service program.

On March 13, 2009, defendant filed the instant motion to alter or amend and clarify the Court's February 27, 2009 order granting plaintiff's motion for preliminary injunction. Plaintiffs filed an opposition on March 23, 2009. A reply was filed on March 30, 2009. After carefully considering the arguments set forth by the parties, the Court finds and concludes as follows.

II. LEGAL STANDARD

Under Federal Rule of Civil Procedure 59(e), a "motion to alter or amend a judgment must be filed no later than 10 days after the entry of the judgment." There are four grounds upon which a Rule 59(e) motion may be granted:

> 1) the motion is necessary to correct manifest errors of law or fact upon which the judgment is based; 2) the moving party presents newly discovered or previously unavailable evidence; 3) the motion is necessary to prevent manifest injustice; or 4) there is an intervening change in controlling law.

Turner v. Burlington Northern Santa Fe R.R., 338 F.3d 1058, 1063 (2003). However, a motion under Fed. R. Civ. P. 59(e) cannot be based on evidence and

arguments that could have reasonably been presented earlier in the litigation. *Carroll v. Nakatani,* 342 F.3d 935, 945 (9th Cir. 2003); Judge William W. Schwarzer, et al., *California Practice Guide: Federal Civil Procedure Before Trial* § 12:159.2 (The Rutter Group 2007).

III. DISCUSSION

Defendant argues that "the Court committed manifest error of law or fact in the Order granting Plaintiff's request for preliminary injunction by: (1) finding that the California Legislature had a duty to consider 'any of the relevant factors' prior to the implementation of AB 1183 . . . ; (2) finding that the legislature did not consider any of the said relevant factors . . . ; and (3) improperly analyzing the evidence regarding the aggregate amount of Medi-Cal reimbursement for all drugs, including multi-source drugs." Mot. at 2.

With regard to the Legislature's duty to consider the relevant factors, defendant argues that the Court was incorrect in its finding that the holding of *Orthopaedic Hosp. v. Belshe,* 103 F.3d 1491 (9th Cir. 1997) (hereinafter, *Orthopaedic II/III*) required the Legislature to consider the relevant factors prior to reducing Medi-Cal reimbursement rates. Mot. at 2. Instead, plaintiff argues, "[i]f there is a legal obligation in § (a)(30) (A) to conduct a study, analysis, or give some sort of consideration of 'EEQ' in making rate changes, the federal Medicaid law is clear that

any such obligation would not be on a state's legislature, but rather on a state's single state agency." Mot. at 4. However, as the Court set forth in its preliminary injunction order, and in the Court's March 9, 2009 preliminary injunction orders in the related action CV 09-722-CAS *California Pharmacists Association, et al. v. David Maxwell Jolly*, the Court disagrees with defendant's reading of *Orthopaedic II/III*, and instead finds that *Orthopaedic II/III* indicates that the body responsible for rate setting (here, the Legislature) must consider the relevant factors prior to or contemporaneously with the adoption of the rates.[3] Therefore, the Court declines to alter or amend its holding regarding the Legislature's responsibility to consider the relevant factors.

With regard to the Court's finding that the Legislature failed to consider the relevant factors, defendant argues that the Court committed "manifest error of law or fact by accepting Plaintiffs' inaccurate argument" regarding the legislative history of AB 1183. Mot. at 6. Defendant requests that the Court take judicial notice of evidence not submitted with its opposition, but submitted with its oppositions in the related action CV 09-722-CAS *California Pharmacists Association, et al. v. David Maxwell Jolly*. This

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[3] The Court notes that the result of this case might have been different had the Legislature delegated the study of the relevant factors to the Department or another body, and subsequently considered the results of that study prior to approving the rate reduction.

evidence, defendant argues, demonstrates that the Legislature did, in fact, consider the relevant factors in passing AB 1183. Plaintiff responds that the evidence and documents submitted by defendant in his request for judicial notice were known and available to the plaintiff at the time of the hearing, and therefore they should not be considered herein. Opp'n at 5. Defendant responds that in fact, defendant's counsel called the Court's attention to similar evidence at the hearing when defendant argued that "AB 1183 just didn't come out of thin air. There were many meetings throughout the year . . . [t]here was a legislative budget committee that worked on it. There were meetings." Reply at 4, citing Reporter's Transcript 7:4-13.

The Court concludes that, regardless of the question of whether defendant properly submitted the evidence on which it now relies in its opposition to plaintiff's motion in this action, the Court fully considered this evidence when it was submitted with defendant's oppositions with regard to motions for preliminary injunction in the related action CV 09-722-CAS *California Pharmacists Association, et al. v. David Maxwell Jolly,* and determined that defendant's evidence did not demonstrate that the Legislature relied on responsible cost studies providing reliable data in setting the rates. Therefore, the Court determines that defendant has failed to demonstrate that the Court committed manifest error of law or fact in determining that the Legislature did not consider the relevant factors.

Finally, with regard to the Court's finding of irreparable harm, defendant argues that the Court erred in finding irreparable harm as to the rate reduction for multi-source drugs, given that the Department's evidence indicated that, after the implementation of the rate reduction, the aggregate Medi-Cal reimbursement for multi-source drugs would be 107 percent to 137 percent of costs. Mot. at 8. Defendant argues that "[i]f the Court concludes that anything less than 100 percent reimbursement of pharmacy costs causes irreparable harm as a result of potential equal access issues, the flip side of that conclusion is that anything above 100 percent reimbursement does not cause irreparable harm." Mot. at 8. Furthermore, defendant argues that the Court's order should be altered "to only enjoin a payment reduction that exceeds 3% on single source drugs," given that the defendants' evidence demonstrates that the reimbursement rate for single source drugs would be 98-99 percent of costs. Mot. at 9.

However, the Court finds that defendant has failed to demonstrate that the Court committed manifest error of fact in finding irreparable harm. The Court considered all of the evidence, including defendant's evidence regarding reimbursement for multi-source drugs, and determined that plaintiffs had demonstrated that the rate reductions would cause irreparable harm, particularly to certain independent pharmacies. As the Court stated in its order, for example, plaintiffs' submitted declarations "show that independent pharmacy providers, who

constitute approximately thirty-three percent of the licensed community pharmacies in California, will be hard-hit by the five percent rate reduction, and may discontinue, or at least severely reduce, services to Medi-Cal beneficiaries." Defendant's showing that the reimbursement rate for multi-source drugs would be over 100 percent of costs on *average* under AB 1183 does not negate plaintiff's showing that some independent pharmacies who may have higher than average costs may be forced to reduce services or to close as a result of the rate reductions. As a result, some Medi-Cal beneficiaries may be irreparably harmed due to lost access to needed services.

IV. CONCLUSION

For the foregoing reasons, the Court DENIES defendant's motion to alter, amend or clarify the Court's February 27, 2009 order.

IT IS SO ORDERED.

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IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

MIKESHA MARTINEZ, et al.,

Plaintiffs,

v.

ARNOLD SCHWARZENEGGER, et al.,

Defendants. /

No. C 09-02306 CW

ORDER GRANTING PLAINTIFFS' MOTION FOR A PRELIMINARY INJUNCTION

(Filed Jun. 26, 2009)

This case is about the implementation of cuts to the wages paid to In-Home Support Services (IHSS) providers, who provide in-home assistance to low-income elderly and disabled individuals through California's Medi-Cal program. The cuts are scheduled to go into effect July 1, 2009. Plaintiffs are a proposed class of individuals who currently receive assistance through IHSS and the unions who represent IHSS providers. In this motion, Plaintiffs seek to enjoin the implementation of the law that will result in cuts to IHSS providers' wages. Defendants Governor Arnold Schwarzenegger, Director of the California Department of Social Services John A. Wagner, Director of the California Department of Health Care Services David Maxwell-Jolly, Fresno County and Fresno County In-Home Supportive Services Public Authority oppose the motion.[1] The matter was heard

[1] Defendant State Controller takes no position in this matter.

on June 25, 2009. Having considered all of the parties' papers and oral argument on the motion, the Court concludes that Plaintiffs have established a strong likelihood of success on their claim that the State Defendants have violated the procedural requirements of the Medicaid Act. The Court also concludes that Plaintiffs will suffer an irreparable injury if the IHSS cuts are implemented and, furthermore, the cuts are reasonably likely to cost the State more money in the long run as individuals currently receiving in-home health services are required to turn to institutionalized care due to the difficulty of finding IHHS providers willing to work for the reduced wages. Accordingly, the Court grants the preliminary injunction.

BACKGROUND[2]

In 1973, California established the IHSS program to provide assistance with the tasks of daily living to low-income elderly and disabled persons "who cannot safely remain in their homes or abodes of their own choosing unless these services are provided." Cal. Welf. & Inst. Code § 12300(a). IHSS

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[2] The Court takes judicial notice of Plaintiffs' exhibits A through X to their request and the State Defendants' exhibits A and B to their request. These documents consist of legislative history and publications by federal, state, local officials and agencies which contain facts that are not subject to reasonable dispute in that they are capable of accurate and ready determination by resort to sources whose accuracy cannot be reasonably questioned.

providers give services such as assistance with bathing, dressing, cooking, feeding, bowel and bladder care, self-administration of medication and cleaning. *Id.* § 12300(b), (c). Over 360,000 IHSS providers serve over 440,000 individuals in California. Over sixty-two percent of IHSS recipients are served by a relative.

IHSS is administered by the State's counties. Fifty-six of California's fifty-eight counties have established either a public authority (PA) or a non-profit consortium (NPC) to provide the delivery of IHSS services. Each of these fifty-six counties has created and maintains a registry from which service providers can be drawn. As of June 30, 2007, there were over 14,500 persons in county registries.[3] These PAs and NPCs are considered employers of IHSS providers for some purposes, including collective bargaining agreements pertaining to providers' wages and benefits; however, individual consumers hire, fire and supervise their own IHSS providers. *Id.* § 12301.6(c)(1).

Each county establishes the providers' wages and benefits. Thus, the rates paid to IHSS providers vary by county. Because most IHSS consumers participate in California's Medicaid program, the federal government pays for about fifty percent of the IHSS program's costs. *See* 42 U.S.C. § 1396d(b). The State pays sixty-five percent and the county pays thirty-five

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[3] The parties did not provide a more recent estimate for the number of IHSS providers in county registries.

percent of the remaining half of the program's costs. Cal. Welf. & Inst. Code § 12306. The State's contribution, however, is subject to a statutory cap. Currently, the maximum State contribution is sixty-five percent of the non-federal share of a wage and benefit package of $12.10 per hour. *Id.* at 12306.1(c)-(d).

Wages and benefits are determined through the collective bargaining process at the county level. Once these wages and benefits are decided, they must be submitted to the California Department of Health Care Services to ensure that they comply with all applicable state and federal laws. *Id.* § 12306.1(a)-(b).

In response to California's unprecedented budget crisis, on February 20, 2009, the Governor signed into law California Welfare and Institutions Code § 12306.1(d)(6). If that law goes into effect on July 1, 2009, the State's maximum contribution in wages and benefits will be reduced from sixty-five percent of the nonfederal share of an hourly rate of $12.10 to sixty-five percent of the non-federal share of an hourly rate of $10.10. This rate represents $9.50 for wages and $0.60 for benefits. Counties do not have to reduce wages and benefits and are permitted to make up the difference between the State's current contribution and any reduction that may result from the State's new maximum contribution.

Only counties that currently pay IHSS providers more than $10.10 per hour in wages and benefits will see a reduction in the State's contribution to IHSS costs. Currently, thirty-four of the fifty-six PAs and

NPCs pay IHSS providers $10.10 per hour or less in wages and benefits. Thus, there will be no reduction in the State's contribution to IHSS costs in a majority of the counties, including Los Angeles, where forty-two percent of all IHSS services are provided. Of the twenty-two counties that currently pay wages and benefits of more than $10.10 per hour to IHSS providers, twelve have notified the State of their intent to reduce IHSS wages in proportion to the anticipated reduction in the State's contribution. Of those twelve counties, Fresno is the only one named as a Defendant. The remaining ten counties have existing labor contracts that will not expire until fall, 2009, and the State does not know what each county will do once those contracts expire.

Fresno is the only county Plaintiffs have sued in this case. On September 26, 2006, the Fresno County Board of Supervisors approved a Memorandum of Understanding (MOU) between the Fresno IHSS Public Authority and the Service Employees International Union, California State Council (SEIU).

The MOU identifies specific contingencies which would permit the County to reduce wages and benefits from their current levels:

> If at any time, federal or state IHSS funding, including monies received through the Realignment Act, are reduced and/or suspended, the Public Authority's participation in pay and wages and/or benefits shall be reduced in direct proportion. The PA shall

> notify the Union of the extent and implementation date of the reduction.
>
> With respect to state realignment and reimbursements, fluctuations in arrears payments within the normal course of the realignment system/process, as of the date of signing the MOU, are not intended to trigger this section.
>
> Fluctuation in total provider service hours do not reduce or increase the per hour wage/benefit rate.

If the union disagrees with a wage or benefit reduction or with the amount of the reduction, the MOU provides that "the parties agree to submit the issue to a neutral third party fact finder for determination of the necessity for and the amount of the reduction." After the bill enacting § 12306.1(d)(6) was signed into law, the Fresno County Board of Supervisors invoked the contingencies article of the MOU to notify the union that it would be reducing the wage and benefits paid to IHSS providers from the current combined hourly rate of $11.10 to a combined hourly rate of $10.10, effective July 1, 2009. If the County continued to pay IHSS providers wages and benefits of $11.10 per hour after the State's maximum contribution is reduced to sixty-five percent of the non-federal portion of a payment of $10.10 per hour, it would incur an additional $6 million in costs annually. The County claims to be in dire financial straits already, with a proposed 2009-2010 budget that anticipates a reduction of $41.44 million in

revenues. The County notes that, as of June 10, 1009 [sic], there are 450 pre-qualified IHSS providers on the county provider registry actively seeking work as an IHSS provider.

In their complaint, Plaintiffs allege that the wage reduction provided in § 12306.1(d)(6) will have a substantial financial impact on tens of thousands of IHSS providers throughout the state. Plaintiffs' expert, Economics Professor Candace Howes, estimates that approximately 4,000 providers will leave IHSS employment because of the rate reduction and that 2,700 IHSS consumers will be unable to find replacements. Howes estimates that over one-fifth of these consumers will try to remain at home without assistance from an IHSS provider, which could be dangerous for the consumer. Roughly half of those unable to find replacement (approximately 1,400) may have to enter skilled-nursing-facilities or other residential institutions.[4] At the hearing on the

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[4] Each side has challenged the admissibility of the evidence submitted by the other side. However, on a motion for a preliminary injunction, the Court may consider inadmissible evidence, giving such evidence appropriate weight depending on the competence, personal knowledge, and credibility of the declarants. 11A Charles A. Wright, Arthur K. Miller & Mary K. Kane, *Federal Practice and Procedure* § 2949 at 216-217 (2d ed.1995); *see also Flynt Distrib. Co. v. Harvey*, 734 F.2d 1389, 1394 (9th Cir. 1984) ("The urgency of obtaining a preliminary injunction necessitates a prompt determination and makes it difficult to obtain affidavits from persons who would be competent to testify at trial. The trial court may give even inadmissible evidence some weight, when to do so serves the

(Continued on following page)

present motion, defense counsel acknowledged that it costs the State more money to pay for individuals in residential institutions than to pay for home health care services.

LEGAL STANDARD

"A plaintiff seeking a preliminary injunction must establish that he is likely to succeed on the merits, that he is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest." *Winter v. Natural Res. Def. Council, Inc.*, ___ U.S. ___, 129 S. Ct. 365, 374 (2008). "[T]he required showing of harm varies inversely with the required showing of meritoriousness." *Indep. Living Ctr. of S. Cal., Inc. v. Shewry*, 543 F.3d 1047, 1049 (9th Cir. 2008) (quoting *Rodeo Collection, Ltd. v. W. Seventh*, 812 F.2d 1215, 1217 (9th Cir. 1987)). "When the balance of harm 'tips decidedly toward the plaintiff,' injunctive relief may be granted if the plaintiff raises questions 'serious enough to require litigation.'" *Id.* (quoting *Benda v. Grand Lodge of the Int'l Ass'n of Machinists & Aerospace Workers*, 584 F.2d 308, 315 (9th Cir. 1978)).

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purpose of preventing irreparable harm.") Therefore, the Court will exercise its discretion to consider the proffered evidence as appropriate.

DISCUSSION

I. Likelihood of Success on the Merits

To receive federal financial participation in payment for services that states provide to low income persons who are aged, blind, disabled or members of families with dependent children, states must agree to comply with applicable federal Medicaid law. *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491, 1493 (9th Cir. 1997). The Medicaid Act requires a participating state to develop a state plan which describes the policy and methods to be used to set payment rates for each type of service included in the program. 42 C.F.R. § 447.201(b). A provision of the Medicaid Act, 42 U.S.C. § 1396a(a)(30)(A) (hereinafter Section 30(A)), requires, in relevant part, that a state's Medicaid plan:

> provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary . . . to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

Defendants urge that Section 30(A) does not compel the state to conduct any studies or analyses regarding the impact of a rate cut. Defendants rely largely on *Sanchez v. Johnson*, 416 F.3d 1051 (9th Cir. 2005),

which they contend limited the holding in *Orthopaedic Hospital* to its facts.

In *Orthopaedic Hospital,* hospital providers sued the California Department of Health Services, claiming that the Director violated Section 30(A) by reducing reimbursement rates without considering the effect of hospital costs on efficiency, economy and quality of care. The Ninth Circuit held that Section 30(A) "provides that payments for services must be consistent with efficiency, economy, and quality of care, and that those *payments* must be sufficient to enlist enough providers to provide access to Medicaid recipients." *Orthopaedic Hosp.,* 103 F.3d at 1496 (emphasis in original). The Ninth Circuit concluded that, under Section 30(A),

> the Director must set hospital outpatient reimbursement rates that bear a reasonable relationship to efficient and economical hospitals' costs of providing quality services, unless the Department shows some justification for rates that substantially deviate from such costs. To do this, the Department must rely on responsible cost studies, its own or others', that provide reliable data as a basis for its rate setting.

Id. The court also concluded, "It is not justifiable for the Department to reimburse providers substantially less than their costs for purely budgetary reasons." *Id.* at 1499 n.3.

Subsequently, in *Sanchez v. Johnson,* 416 F.3d 1051, 1060 (9th Cir. 2005), the Ninth Circuit held

that Section 30(A) does not confer individual rights that are enforceable under 42 U.S.C. § 1983.[4] *Sanchez* left undisturbed the rule announced in *Orthopaedic Hospital* that Section 30(A) "requires the state to consider efficiency, economy, quality of care, and access before setting Medi-Cal reimbursement rates." *California Pharmacists Assoc. v. Maxwell-Jolly*, 563 F.3d 847, 850 (9th Cir. 2009) (citing *Orthopaedic Hosp.*, 103 F.3d at 1496).

Here, the State Defendants concede that the California legislature did not consider the Section 30(A) factors when it adopted California Welfare and Institutions Code § 12301(d)(6). The bill implementing § 12301(d)(6) states only that the new law "addresses the fiscal emergency declared by the Governor by proclamation on December 19, 2008." No analysis in the legislative history mentions the impact of the provision on access to care or the quality of care.

Defendants argue that they need not consider the Section 30(A) factors because the wages and benefits paid to IHSS providers are set by the counties' PA or NPC, often after collective bargaining. Defendants assert that the State has no influence in determining what the wages will be in each county. However

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[4] However, in *Independent Living Center of Southern California, Inc. v. Shewry*, 543 F.3d 1050, 1058 (9th Cir. 2008), the Ninth Circuit held that a plaintiff may sue for injunctive relief directly under the Supremacy Clause. Here, Plaintiffs sue under that clause.

§ 12306.1(d)(6) has a direct influence on the wages for each county because it reduces the maximum payment towards wages and benefits that the State will contribute. Through § 12306.1(d)(6), the State directly informed all counties that it would no longer be able to contribute more than sixty-five percent of the non-federal portion of $10.10 per hour in wages and benefits. Further, a county's role in determining IHHS wages and benefits does not preclude the State from analyzing the impact of Section 12306.1(d)(6) on the Section 30(A) factors prior to enactment. Accordingly, the Court concludes that Plaintiffs have made a strong showing of likelihood of success on the merits that Defendants violated the procedural requirements of Section 30(A).

Because the Court concludes that a preliminary injunction is warranted based on Plaintiffs' likelihood of success on their procedural claim, the Court need not determine the likelihood of Plaintiffs' success on their claim that Defendants violated the substantive requirements of Section 30(A) or their claim that Defendants violated the Americans with Disabilities Act.

II. Irreparable Harm, Balance of Hardships and the Public Interest

IHSS consumers will suffer immediate and irreparable harm unless the Court issues a preliminary injunction. The wage reductions will cause many IHSS providers to leave employment, which in turn

will leave consumers without IHSS assistance. The consumers' quality of life and health-care will be greatly diminished, which will likely cause great harm to disabled individuals. For instance, the declarations submitted by Plaintiffs describe harms ranging from going hungry and dehydration, to falls and burns, to an inability ever to leave the home. Institutionalizing individuals that can comfortably survive in their home with the help of IHSS providers will "cause Plaintiffs to suffer injury to their mental and physical health, including a shortened life, and even death for some Plaintiffs." *Crabtree v. Goetz*, 2008 WL 5330506, at *30 (M.D. Tenn.).

IHSS providers will also suffer immediate and irreparable harm. Although financial injury is generally not adequate to establish irreparable harm, *L.A. Mem'l Coliseum Comm'n v. Nat'l Football League*, 643 F.2d 1197, 1202 (9th Cir. 1980), financial harm to the IHSS providers is irreparable because retrospective monetary damages are unavailable due to the State Defendants' Eleventh Amendment immunity. *California Pharmacists*, 563 F.3d at 851-52 ("[B]ecause the Hospital Plaintiffs and their members will be unable to recover damages against the Department even if they are successful on the merits of their case, they will suffer irreparable harm if the requested injunction is not granted.")

The balance of hardships and the public interest also weigh in Plaintiffs' favor. If the preliminary injunction does not issue, the State Defendants' sole injury will be the financial costs associated with

continuing to participate under the current IHSS provider wages. The Court notes that there is persuasive evidence that the wage cuts will actually cost the State tens of millions of additional dollars because in-home care is considerably less expensive than institutionalized care and IHHS providers reduce the need for expensive emergency room visits. Accordingly, the financial loss the State will suffer if Section 12306.1(d)(6) is not implemented does not outweigh the hardship Plaintiffs would suffer absent an injunction. Lastly, the public interest weighs heavily in favor of granting relief. "It would be tragic, not only from the standpoint of the individuals involved but also from the standpoint of society, were poor, elderly, disabled people to be wrongfully deprived of essential benefits for any period of time." *Lopez v. Heckler,* 713 F.2d 1432, 1437 (9th Cir. 1983).

CONCLUSION

For the foregoing reasons, the Court grants Plaintiffs' motion for a preliminary injunction. As set forth in the separately filed preliminary injunction, Defendants are enjoined and restrained from implementing California Welfare and Institutions Code § 12306.1(d)(6) without first conducting the analysis required by Section 30(A), as described in *Orthopaedic Hospital.*

IT IS SO ORDERED.

Dated: 6/26/09 /s/ Claudia Wilken
CLAUDIA WILKEN
United States District Judge

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

MIKESHA MARTINEZ, et al.,

Plaintiffs,

v.

ARNOLD SCHWARZENEGGER, et al.,

Defendants. /

No. C 09-02306 CW

PRELIMINARY INJUNCTION

IT IS HEREBY ORDERED that Defendants ARNOLD SCHWARZENEGGER, Governor of the State of California; JOHN A. WAGNER, Director of the California Department of Social Services; DAVID MAXWELL-JOLLY, Director of the California Department of Health Care Services; JOHN CHIANG, California State Controller; and their officers, agents, servants, employees, and attorneys, and those persons in active concert or participation with them, are HEREBY ENJOINED AND RESTRAINED from implementing California Welfare and Institutions Code § 12306.1(d)(6) without first conducting the analysis required by 42 U.S.C. § 1396a(a)(30)(A), as described in *Orthopaedic Hospital v. Belshe*, 103 F.3d 1941, 1493 [sic] (9th Cir. 1997).

A reasoned written order will follow.

IT IS SO ORDERED.

Dated: 6/26/2009 /s/ Claudia Wilken
CLAUDIA WILKEN
United States District Judge

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN
DISTRICT OF CALIFORNIA

MIKESHA MARTINEZ, et al.,

Plaintiffs,

v.

ARNOLD
SCHWARZENEGGER, et al.,

Defendants.

No. C 09-02306 CW

**AMENDED
PRELIMINARY
INJUNCTION**

IT IS HEREBY ORDERED that Defendants **ARNOLD SCHWARZENEGGER, Governor of the State of California; JOHN A. WAGNER, Director of the California Department of Social Services; DAVID MAXWELL-JOLLY, Director of the California Department of Health Care Services; JOHN CHIANG, California State Controller; and their officers, agents, servants, employees, and attorneys, and those persons in active concert or participation with them, are HEREBY ENJOINED AND RESTRAINED from implementing California Welfare and Institutions Code § 12306.1(d)(6) without first conducting the analysis required by 42 U.S.C. § 1396a(a)(30)(A), as described in *Orthopaedic Hospital v. Belshe*, 103 F.3d 1941, 1493 [sic] (9th Cir. 1997). IT IS FURTHER ORDERED that State Defendants shall, by the close of business on July 14, 2009, rescind the State's approval of all county rate reduction requests which were submitted after February 20, 2009, to be effective July 1, 2009,**

and reinstate the State's approval of the pre-July 1 rates. The State shall notify each affected county of these action [sic], using a method designed to ensure that the notification is received on July 14. At the same time, the State will notify these counties that it will pay sixty-five percent of the non-federal share of the pre-July 1, 2009 rate up to $12.10 for hours worked on July 1 and thereafter, until such time as the Court's preliminary injunction is rescinded. The State shall include a copy of the Court's amended injunction in its communication to the counties. The State may notify the counties that they may submit new Rate Change Requests if they wish to pursue a rate change for reasons other than the passage of § 12306.1(d)(6).

IT IS SO ORDERED.

Dated: 07/13/09 /s/ Claudia Wilken
CLAUDIA WILKEN
United States District Judge

IN THE UNITED STATES DISTRICT COURT

FOR THE NORTHERN DISTRICT OF CALIFORNIA

MIKESHA MARTINEZ, et al.,

Plaintiffs,

v.

ARNOLD SCHWARZENEGGER, et al.,

Defendants. /

No. C 09-02306 CW

ORDER FURTHER CLARIFYING INJUNCTION

(Filed Jul. 24, 2009)

On June 26, 2009, the Court enjoined and restrained Defendants from implementing California Welfare and Institutions Code § 12306.1(d)(6) without first conducting the analysis required by 42 U.S.C. § 1396a(a)(30)(A), as described in *Orthopaedic Hospital v. Belshe*, 103 F.3d 1941, 1943 (9th Cir. 1997). In response to Plaintiffs' motion for civil contempt sanctions, or in the alternative, for a more specific injunction, the Court issued an order clarifying the injunction. The Court ordered that "State Defendants shall, by the close of business on July 14, 2009, rescind the State's approval of all county rate reduction requests which were submitted after February 20, 2009, to be effective July 1, 2009, and reinstate the State's approval of the pre-July 1 rates." Amd. Prelim. Inj. at 1. The Court also stated, "The State may notify the counties that may submit new Rate Change Requests if they wish to pursue a rate change for reasons other than the passage of § 12306.1(d)(6)."

Order Clarifying Inj. at 6. With respect to Fresno County, the Court noted,

> It is not clear from the papers submitted by the parties whether Fresno County submitted one Rate Change Request with a second reason for the request other than the passage of § 12306.1(d)(6) or if it submitted two requests. If it submitted only one request, it must submit a separate request based on a reason other than § 12306.1(d)(6) if it wishes to pursue a rate reduction.

Id. at 6 n.4.

Although the order clarifying the injunction specifically instructed State Defendants to "rescind the State's approval of *all* county rate reduction requests which were submitted after February 20, 2009," (emphasis added) California Department of Social Services (CDSS) official Eileen Carroll instead contacted several counties to see if they wanted to revert to the pre-July 1, 2009 wage. Officials of Fresno County and Santa Barbara County indicated that they did not want return to the pre-July 1 wage because they claim a separate and independent reason for their rate reduction. Fresno County officials assert that it had filed a separate Rate Change Request on June 24, giving a separate and independent ground for its rate reduction; and Santa Barbara County officials subsequently submitted a

similar Rate Change Request on July 21.[1] The State did not rescind its approval of Fresno County's and Santa Barbara County's rate reduction request.

Carroll also told at least one In-Home Support Services (IHSS) Public Authority that if State Defendants prevailed in the instant lawsuit and § 12301.6(d)(d) is eventually implemented, counties would be reasonsible for the state contribution above $9.50 retroactive to July 1, 2009. Arkush Supp. Decl. ¶ 2. The Court has made no such ruling.

On July 14, 2009, State Defendants issued a notice to all counties informing them that the State would not begin paying the pre-July 1 rates until July 23. State Defendants claim that the Department of Social Services could not change the levels of wages and benefits to be paid to IHSS providers in its Case Management, Information and Payrolling System (CMIPS) until July 23. By that date, the CMIPS system would be reprogrammed. Even after July 23, State Defendants will not pay the pre-July 1 levels of wages and benefits retroactively to July 1 until the counties submit a supplemental pay warrant. State Defendants claim, "Under DSS regulations counties

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[1] The parties acknowledge that Contra Costa County has indicated that, instead of reverting to the pre-July 1 wage rate, it intends to implement its more recent rate request, which seeks to implement wages above the pre-July 1 level. Plaintiffs do not oppose this decision.

are required to process all supplemental payments."[2] Letter from State Defendants to Judge Wilken Re Complying with Amended Preliminary Injunction. In order to submit a supplemental pay warrant, according to State Defendants, counties must "complete a 'spec transaction'" that will take [sic] "take 20-25 minutes per case."[3] All-County Welfare Director's Letter at 3.

Plaintiffs have now filed another motion for civil contempt sanctions and for a further, more specific preliminary injunction. Defendants oppose the motion. Having considered the papers filed by the parties, the Court further clarifies its injunction and takes Plaintiffs' motion for contempt sanctions under submission.

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[2] Although State Defendants do not cite any particular regulations for this requirement, it appears that they are referring to Social Services Standard 30-769.252, which provides, "The county shall initiate emergency/supplemental checks" in certain situations, including "[p]ayments for other unusual situations not provided for by the regular payrolling process." Nothing in this standard prohibits the State from initiating a supplemental payment on its own.

[3] According to the State, each county must manually calculate the difference between the reduced wage and the reinstated wage, multiply that figure by the number of hours worked at the reduced wage, and enter that amount into the CMIPS. Plaintiffs estimate that this process would take a small county such as San Benito, which only has 420 IHSS consumers, up to ten working days to complete.

DISCUSSION

Under the plain terms of the Court's amended preliminary injunction, State Defendants were ordered to, "by close of business on July 14, 2009, rescind the State's approval of all county rate reduction requests which were submitted after February 20, 2009, to be effective July 1, 2009, and reinstate the State's approval of the pre-July 1, rates." Amd. Prelim. Inj. at 2. The Court was specific in its order because, up until that point, State Defendants' manner of compliance with the original preliminary injunction did not carry out the intent of the order. Thus, when State Defendants refused to rescind their approval of Santa Barbara's rate reduction request submitted during the specified time period, they were in violation of the Court's amended injunction.

The facts related to Fresno County's Rate Change Request are more complicated. On April 30, 2009, Fresno County had submitted a Rate Change Request packet to the CDSS. Included in the packet was form SOC 449, entitled "In-Home Supportive Services Program Public Authority/Non-Profit Consortium Rate." Also in the packet, Fresno County included the April 28, 2009 Board of Supervisors' Agenda Item, in which the Board stated, "Based on the state maximum participation decrease in wages and benefits and the contingency language in the Memorandum of Understanding, the rate packet will insure that the provider wage decrease from $10.25 to $9.50 and benefit decrease from $.85 to $.60 per hour becomes effective July 1, 2009." The Memorandum of Understanding

provides specific contingencies which would permit Fresno to pay lower wages and benefits to IHSS providers.

On June 16, 2009, the Board had approved an agenda item for a $1.00 decrease in wages and benefits based on a purported budget realignment shortfall. The agenda item stated that there would be "no increase in net County cost associated with this action as the recommendation mirrors the recommendation adopted by the Governing Board on April 28, 2009." Leyton Second Supp. Decl., Ex. C (June 16 Agenda Item at 1). The agenda item further stated,

> The $1.00 recommended reduction before you today is specific to the Realignment deficit, and it is recommended that the reduction be divided between wages ($0.75) and benefits ($0.25) to be consistent with the State law change and the Public Authority Rate packet approved by the Governing Board on April 28, 2009. The approval of the recommended action would add a secondary reason to the rate packet submitted to the State, but is not an additional wage/benefits reduction.

Id. at 2.

On June 24, 2009, Fresno County submitted a letter to CDSS stating,

> Enclosed is the approved Board agenda item supporting the Fresno County submission of State Form SOC 449 sent to you on April 30, 2009. Please note that there are no changes that will be made to the submitted SOC 449

> form. Independent of the State law changes, on June 16, 2009, the Fresno County Board of Supervisors, sitting as the In-Home Supportive Services Public Authority Governing Board (Governing Board), voted to decrease wages and benefits due to loss of realignment funding.

Form SOC 449 is a budget narrative and does not include any information regarding the reasons for seeking approval of a rate change. Thus, a second reason for reducing wages did not affect the budget narrative provided in SOC 449.

As noted above, the Court ordered State Defendants to notify counties that they may submit new Rate Change Requests if they wished to pursue a rate change for reasons other than the passage of § 12306.1(d)(6). The Court noted that if Fresno County had submitted only a single previous Rate Change Request, with a second reason for the request other than the passage of § 12306.1(d)(6), and it wished to pursue a rate reduction, it would have to submit a separate request based on a reason other than § 12306.1(d)(6). The Court concludes that the June 24, 2009 letter merely expresses a second reason for its initial rate change request submitted on April 30, 2009. The letter does not constitute a second rate change request.

Moreover, at the time the Fresno County Board of Supervisors voted to submit the realignment shortfall as a separate reason for the April 30, 2009 Rate Change Request, § 12306.1(d)(6) was good law

and scheduled to go into effect on July 1, 2009. Thus, Fresno County either had to reduce its rate or make up the shortfall that the cut in the State's contribution would have created. Many presentations were made to the Board about the fiscal impact of the proposed rate cut, and these presentations presumed that § 12306.1(d)(6) would be implemented on July 1, 2009. The possibility that § 12306.1(d)(6) could be enjoined was not discussed at the Board meeting. Therefore, unless Fresno County submits a new Rate Change Request solely based on a reason other than the passage of § 12306.1(d)(6), it will not be clear whether the Fresno County Board of Supervisors would vote to seek a rate reduction knowing that § 12306.1(d)(6) has been preliminary enjoined.

Thus, to comply with the plain language of the Court's order clarifying the injunction, the State must rescind its prior approval of Santa Barbara and Fresno County's Rate Change Requests. To avoid misunderstandings, these rescissions must be in writing and be sent by overnight delivery within one business day from the date of this order. At the same time, a copy must be submitted to Plaintiffs' counsel and to the Court, along with a declaration under penalty of perjury verifying that it was sent. Before the State may approve a rate reduction for Santa Barbara or Fresno County, it must receive from the County a new and separate written request conforming to all the requirements of law and regulation, based on a reason other than § 12306.1(d)(6). A copy of this request shall be sent to the Court and to Plaintiffs'

counsel. The State may then approve the request in writing, if it accords with law and regulation.

The State must correct the underpayments made to providers for the July 1-15 pay period. The State has cited no regulation preventing it from preparing supplemental pay warrants. Counties should not be burdened with correcting the mistakes caused by State Defendants' violation of the federal Medicaid statute and failure to implement timely the Court's orders.

Therefore, State Defendants must pay IHSS providers, in all counties where the State has rescinded its approval of Rate Change Requests that proposed rate decreases to take effect July 1, 2009, at the correct, pre-July 1 rates in their regular paychecks for the pay period ending July 31, 2009. State Defendants must also pay all IHSS providers the correct amount owed for the pay period ending July 15, 2009 in a check or checks that issue no later than ten days after the provider submits his or her timesheet for that pay period, or seven business days from the date of this order, whichever is later. State Defendants shall file a declaration eight business days from the date of this order, verifying that they have done so or showing cause why they have not. In any county in which the State has approved an increase from the pre-July 1 rate, State Defendants shall pay such increased rate.

Plaintiffs' motion for civil contempt sanctions and attorneys' fees is taken under submission.

IT IS SO ORDERED.

Dated: 07/24/09 /s/ Claudia Wilken
CLAUDIA WILKEN
United States District Judge

Assembly Bill No. 5

CHAPTER 3

An act to amend Section 95004 of the Government Code, and to amend Sections 4640.6, 4643, 4648.4, 4681.3, 4681.5, 4691.6, 4781.6, and 4783 of, and to add Sections 4681.6, 4689.8, 4691.9, 14041.1, 14105.19, and 14166.245 to, the Welfare and Institutions Code, relating to health, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor February 16, 2008.
Filed with Secretary of State February 16, 2008.]

LEGISLATIVE COUNSEL'S DIGEST

AB 5, Committee on Budget. Public health programs.

* * *

Existing law establishes the Medi-Cal Hospital/Uninsured Care Demonstration Project Act, which revises hospital reimbursement methodologies under the Medi-Cal program in order to maximize the use of federal funds consistent with federal Medicaid law and stabilize the distribution of funding for hospitals that provide care to Medi-Cal beneficiaries and uninsured patients. This demonstration project provides for funding, in supplementation of Medi-Cal reimbursement, to various hospitals, including designated public hospitals, nondesignated public hospitals, and private hospitals, as defined in accordance with certain provisions relating to disproportionate share hospitals.

This bill would reduce by 10% payments for inpatient hospital services to acute care hospitals not under selective contracts with the department that are provided on and after July 1, 2008.

The California Constitution authorizes the Governor to declare a fiscal emergency and to call the Legislature into special session for that purpose. The Governor issued a proclamation declaring a fiscal emergency, and calling a special session for this purpose, on January 10, 2008.

This bill would state that it addresses the fiscal emergency declared by the Governor by proclamation issued on January 10, 2008, pursuant to the California Constitution.

This bill would declare that it is to take effect immediately as an urgency statute.

The people of the State of California do enact as follows:

* * *

SEC. 14. Section 14105.19 is added to the Welfare and Institutions Code, to read:

14105.19. (a) Notwithstanding any other provision of law, in order to implement changes in the level of funding for health care services, the director shall reduce provider payments as specified in this section.

(b)(1) Except as provided in subdivision (c), payments shall be reduced by 10 percent for Medi-Cal

fee-for-service benefits for dates of service on and after July 1, 2008.

(2) Except as provided in subdivision (c), payments shall be reduced by 10 percent for non-Medi-Cal programs described in Article 6 (commencing with Section 124025) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, and Section 14105.18, for dates of service on and after July 1, 2008.

(3) For managed health care plans that contract with the department pursuant to this chapter, Chapter 8 (commencing with Section 14200), and Chapter 8.75 (commencing with Section 14590), payments shall be reduced by the actuarial equivalent amount of the payment reduction specified in this subdivision pursuant to contract amendments or change orders effective on July 1, 2008.

(c) The services listed in this subdivision shall be exempt from the payment reductions specified in subdivision (b):

(1) Acute hospital inpatient services, except for payments to hospitals not under contract with the State Department of Health Care Services, as provided in Section 14166.245.

(2) Federally qualified health center services, including those facilities deemed to have federally qualified health center status pursuant to a waiver under subdivision (a) of Section 1315 of Title 42 of the United States Code.

(3) Rural health clinic services.

(4) All of the following facilities:

(A) A skilled nursing facility pursuant to subdivision (c) of Section 1250 of the Health and Safety Code, except a skilled nursing facility that is a distinct part of a general acute care hospital. For purposes of this paragraph, "distinct part" has the same meaning as defined in Section 72041 of Title 22 of the California Code of Regulations.

(B) An intermediate care facility for the developmentally disabled pursuant to subdivision (e), (g), or (h) of Section 1250 of the Health and Safety Code, or a facility providing continuous skilled nursing care to developmentally disabled individuals pursuant to the pilot project established by Section 14495.10.

(C) A subacute care unit, as defined in Section 51215.5 of Title 22 of the California Code of Regulations.

(5) Payments to facilities owned or operated by the State Department of Mental Health or the State Department of Developmental Services.

(6) Hospice.

(7) Contract services as designated by the director pursuant to subdivision (e).

(8) Payments to providers to the extent that the payments are funded by means of a certified public expenditure or an intergovernmental transfer

pursuant to Section 433.51 of Title 42 of the Code of Federal Regulations.

(9) Services pursuant to local assistance contracts and interagency agreements to the extent the funding is not included in the funds appropriated to the department in the annual Budget Act.

(10) Payments to Medi-Cal managed care plans pursuant to Section 4474.5 for services to consumers transitioning from Agnews Developmental Center into Alameda, San Mateo, and Santa Clara Counties pursuant to the Plan for the Closure of Agnews Developmental Center.

(11) Breast and cervical cancer treatment provided pursuant to Section 14007.71.

(12) The Family Planning, Access, Care, and Treatment (Family PACT) Waiver Program pursuant to Section 14105.18.

(d) Subject to the exception for services listed in subdivision (c), the payment reductions required by subdivision (b) shall apply to the services rendered by any provider who may be authorized to bill for the service, including, but not limited to, physicians, podiatrists, nurse practitioners, certified nurse midwives, nurse anesthetists, and organized outpatient clinics.

(e) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this section by means of a provider bulletin,

or similar instruction, without taking regulatory action.

(f) The reductions described in this section shall apply only to payments for services when the General Fund share of the payment is paid with funds directly appropriated to the department in the annual Budget Act and shall not apply to payments for services paid with funds appropriated to other departments or agencies.

(g) The department shall promptly seek any necessary federal approvals for the implementation of this section.

SEC. 15. Section 14166.245 is added to the Welfare and Institutions Code, to read:

14166.245. (a) The Legislature finds and declares that the state faces a fiscal crisis that requires unprecedented measures to be taken to reduce General Fund expenditures to avoid reducing vital government services necessary for the protection of the health, safety, and welfare of the citizens of the State of California.

(b) Notwithstanding any other provision of law, for acute care hospitals not under contract with the State Department of Health Care Services pursuant to Article 2.6 (commencing with Section 14081) of Chapter 7 of Part 3 of Division 9, the amounts paid as interim payments for inpatient hospital services provided on and after July 1, 2008, shall be reduced by 10 percent.

(c)(1) Notwithstanding any other provision of law, for acute care hospitals not under contract with the State Department of Health Care Services, the reimbursement amount for inpatient services provided to Medi-Cal recipients for dates of service on and after July 1, 2008, shall not exceed the amount determined pursuant to paragraph (3).

(2) For purposes of this subdivision, the reimbursement for inpatient services includes the amounts paid for all categories of inpatient services allowable by Medi-Cal. The reimbursement includes the amounts paid for routine services, together with all related ancillary services.

(3) When calculating a hospital's cost report settlement for a hospital's fiscal period that includes any dates of service on and after July 1, 2008, the settlement for dates of service on and after July 1, 2008, shall be limited to 90 percent of the hospital's audited allowable cost per day for those services multiplied by the number of Medi-Cal covered inpatient days in the hospital's fiscal year on or after July 1, 2008.

(d) Hospitals that participate in the Selective Provider Contracting Program pursuant to Article 2.6 (commencing with Section 14081) and designated public hospitals under Section 14166.1, except Los Angeles County Martin Luther King, Jr./Charles R. Drew Medical Center and Tuolumne General Hospital, shall be exempt from the 10 percent reduction required by this section.

(e) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the director may implement subdivision (b) by means of a provider bulletin, or other similar instruction, without taking regulatory action.

(f) The director shall promptly seek all necessary federal approvals in order to implement this section, including necessary amendments to the state plan.

SEC. 16. This act addresses the fiscal emergency declared by the Governor by proclamation on January 10, 2008, pursuant to subdivision (f) of Section 10 of Article IV of the California Constitution.

SEC. 17. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make statutory changes needed to implement cost containment measures affecting health services, at the earliest possible time, it is necessary that this act take effect immediately.

Assembly Bill No. 1183

CHAPTER 758

An act to amend Sections 1266, 1279, 1324.21, 1324.23, 1324.28, 1324.29, 1324.30, 2805, 106925, 123853, 125191, 130501, 130506, and 130542 of, and to add Section 130542.1 to, the Health and Safety Code, to amend Sections 12693.43, 12693.63, and 12693.65 of, and to add Section 12693.271 to, the Insurance Code, and to amend Sections 4061, 4783, 4860, 5777, 14005.11, 14007.9, 14011.16, 14080, 14105.19, 14105.3, 14105.86, 14126.027, 14126.033, 14154, 14154.5, 14166.9, 14166.12, 14166.20, 14166.25, 14301.1, 14526.1, and 16809 of, to amend, repeal, and add Sections 14005.25 and 14166.245 of, to add Sections 4100.2, 4646.4, 7502.5, 14005.42, 14011.17, 14011.18, 14053.3, 14104.93, 14105.191, 14124.11, 14126.034, and 17605.051 to, and to add and repeal Article 2.93 (commencing with Section 14091.3), and Article 6.6 (commencing with Section 14199) of, Chapter 7 of Part 3 of Division 9 of, the Welfare and Institutions Code, relating to public health, making an appropriation therefor, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor September 30, 2008. Filed with Secretary of State September 30, 2008.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1183, Committee on Budget. Health.

* * *

Existing law contains various provisions governing reimbursement rates, including rates for fee-for-service payments to Medi-Cal providers, and for providers of services received under various health programs, including the above-described programs, the Child Health and Disability Prevention Program, and specified family planning programs.

Existing law requires the Director of Health Care Services to reduce provider payments by 10% for both Medi-Cal fee-for-service benefits and services rendered by providers under these health programs for services rendered on or after July 1, 2008.

This bill would revise these provisions to require the 10% reduction of reimbursement rates to apply to services rendered on or after July 1, 2008, through and including dates of service on February 28, 2009. The bill would, for services rendered on a fee-for-services basis on or after March 1, 2009, require the director to reduce payments for certain benefits, including for services rendered by providers under the above-described health programs, by 1%, and to reduce payments to specified classes of providers and pharmacies by 5%, subject to certain exceptions. The bill would exempt small and rural hospitals, as defined, from the reduction, under specified circumstances.

The bill would specify that the reductions imposed pursuant to the bill would apply only to the General Fund share of the payment, and only to

payments for services from funds appropriated to the department.

To the extent federal financial participation is not available with respect to any of the payment reductions required pursuant to these provisions, the bill would authorize the director to not implement those payment reductions.

* * *

Existing law reduces by 10% payments for inpatient hospital services to acute care hospitals not under selective contracts with the department that are provided on and after July 1, 2008.

This bill, until January 1, 2013, would revise this provision by applying this reduction to all hospitals that receive Medi-Cal reimbursement from the department and that are not under selective contracts with the department. The bill, commencing October 1, 2008, and until January 1, 2013, would require the amounts paid for inpatient hospital services to be determined using a prescribed formula, subject to specified exceptions. If specified hospitals choose to enter into selective contracts with the department, the bill would require the California Medical Assistance Commission to negotiate reimbursement rates for those hospitals in accordance with specified criteria. The bill would require the department to report annually, from January 1, 2010, to January 1, 2012, inclusive, to the Legislature on

the implementation and impact made by the changes to these rate reduction provisions.

* * *

This bill would declare that it is to take effect immediately as an urgency statute.

Appropriation: yes.

The people of the State of California do enact as follows:

* * *

SEC. 44. Section 14105.19 of the Welfare and Institutions Code is amended to read:

14105.19. (a) Notwithstanding any other provision of law, in order to implement changes in the level of funding for health care services, the director shall reduce provider payments as specified in this section.

(b)(1) Except as provided in subdivision (c), payments shall be reduced by 10 percent for Medi-Cal fee-for-service benefits for dates of service on and after July 1, 2008, through and including dates of service on February 28, 2009.

(2) Except as provided in subdivision (c), payments shall be reduced by 10 percent for non-Medi-Cal programs described in Article 6 (commencing with Section 124025) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, and Section 14105.18, for dates of service on and after

July 1, 2008, through and including dates of service on February 28, 2009.

(3) For managed health care plans that contract with the department pursuant to this chapter, Chapter 8 (commencing with Section 14200), and Chapter 8.75 (commencing with Section 14590), payments shall be reduced by the actuarial equivalent amount of the payment reduction specified in this subdivision pursuant to contract amendments or change orders effective on July 1, 2008.

(4) Notwithstanding paragraphs (1) and (2), payment reductions set forth in this subdivision shall apply to small and rural hospitals, as defined in Section 124840 of the Health and Safety Code, for dates of service on and after July 1, 2008, through and including October 31, 2008.

(c) The services listed in this subdivision shall be exempt from the payment reductions specified in subdivision (b):

(1) Acute hospital inpatient services, except for payments to hospitals not under contract with the State Department of Health Care Services, as provided in Section 14166.245.

(2) Federally qualified health center services, including those facilities deemed to have federally qualified health center status pursuant to a waiver under subdivision (a) of Section 1315 of Title 42 of the United States Code.

(3) Rural health clinic services.

(4) All of the following facilities:

(A) A skilled nursing facility pursuant to subdivision (c) of Section 1250 of the Health and Safety Code, except a skilled nursing facility that is a distinct part of a general acute care hospital. For purposes of this paragraph, "distinct part" has the same meaning as defined in Section 72041 of Title 22 of the California Code of Regulations.

(B) An intermediate care facility for the developmentally disabled pursuant to subdivision (e), (g), or (h) of Section 1250 of the Health and Safety Code, or a facility providing continuous skilled nursing care to developmentally disabled individuals pursuant to the pilot project established by Section 14495.10.

(C) A subacute care unit, as defined in Section 51215.5 of Title 22 of the California Code of Regulations.

(5) Payments to facilities owned or operated by the State Department of Mental Health or the State Department of Developmental Services.

(6) Hospice.

(7) Contract services as designated by the director pursuant to subdivision (e).

(8) Payments to providers to the extent that the payments are funded by means of a certified public expenditure or an intergovernmental transfer pursuant to Section 433.51 of Title 42 of the Code of Federal Regulations.

(9) Services pursuant to local assistance contracts and interagency agreements to the extent the funding is not included in the funds appropriated to the department in the annual Budget Act.

(10) Payments to Medi-Cal managed care plans pursuant to Section 4474.5 for services to consumers transitioning from Agnews Developmental Center into Alameda, San Mateo, and Santa Clara Counties pursuant to the Plan for the Closure of Agnews Developmental Center.

(11) Breast and cervical cancer treatment provided pursuant to Section 14007.71.

(12) The Family Planning, Access, Care, and Treatment (Family PACT) Waiver Program pursuant to Section 14105.18.

(d) Subject to the exception for services listed in subdivision (c), the payment reductions required by subdivision (b) shall apply to the services rendered by any provider who may be authorized to bill for the service, including, but not limited to, physicians, podiatrists, nurse practitioners, certified nurse midwives, nurse anesthetists, and organized outpatient clinics.

(e) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement this section by means of a provider bulletin, or similar instruction, without taking regulatory action.

(f) The reductions described in this section shall apply only to payments for services when the General Fund share of the payment is paid with funds directly appropriated to the department in the annual Budget Act and shall not apply to payments for services paid with funds appropriated to other departments or agencies.

(g) The department shall promptly seek any necessary federal approvals for the implementation of this section.

SEC. 45. Section 14105.191 is added to the Welfare and Institutions Code, to read:

14105.191. (a) Notwithstanding any other provision of law, in order to implement changes in the level of funding for health care services, the director shall reduce provider payments, as specified in this section.

(b)(1) Except as otherwise provided in this section, payments shall be reduced by 1 percent for Medi-Cal fee-for-service benefits for dates of service on and after March 1, 2009.

(2) Except as provided in subdivision (d), for dates of service on and after March 1, 2009, payments to the following classes of providers shall be reduced by 5 percent for Medi-Cal fee-for-service benefits:

(A) Intermediate care facilities, excluding those facilities identified in paragraph (5) of subdivision (d). For purposes of this section, "intermediate care facility" has the same meaning as defined in Section

51118 of Title 22 of the California Code of Regulations.

(B) Skilled nursing facilities that are distinct parts of general acute care hospitals. For purposes of this section, "distinct part" has the same meaning as defined in Section 72041 of Title 22 of the California Code of Regulations.

(C) Rural swing-bed facilities.

(D) Subacute care units that are, or are parts of, distinct parts of general acute care hospitals. For purposes of this subparagraph, "subacute care unit" has the same meaning as defined in Section 51215.5 of Title 22 of the California Code of Regulations.

(E) Pediatric subacute care units that are, or are parts of, distinct parts of general acute care hospitals. For purposes of this subparagraph, "pediatric subacute care unit" has the same meaning as defined in Section 51215.8 of Title 22 of the California Code of Regulations.

(F) Adult day health care centers.

(3) Except as provided in subdivision (d), for dates of service on and after March 1, 2009, Medi-Cal fee-for-service payments to pharmacies shall be reduced by 5 percent.

(4) Except as provided in subdivision (d), payments shall be reduced by 1 percent for non-Medi-Cal programs described in Article 6 (commencing with

Section 124025) of Chapter 3 of Part 2 of Division 106 of the Health and Safety Code, and Section 14105.18, for dates of service on and after March 1, 2009.

(5) For managed health care plans that contract with the department pursuant to this chapter, Chapter 8 (commencing with Section 14200), and Chapter 8.75 (commencing with Section 14590), payments shall be reduced by the actuarial equivalent amount of the payment reductions specified in this subdivision pursuant to contract amendments or change orders effective on July 1, 2008, or thereafter.

(c) Notwithstanding any other provision of this section, payments to hospitals that are not under contract with the State Department of Health Care Services pursuant to Article 2.6 (commencing with Section 14081) for inpatient hospital services provided to Medi-Cal beneficiaries and that are subject to Section 14166.245 shall be governed by that section.

(d) To the extent applicable, the services, facilities, and payments listed in this subdivision shall be exempt from the payment reductions specified in subdivision (b):

(1) Acute hospital inpatient services that are paid under contracts pursuant to Article 2.6 (commencing with Section 14081).

(2) Federally qualified health center services, including those facilities deemed to have federally qualified health center status pursuant to a waiver

pursuant to subsection (a) of Section 1115 of the federal Social Security Act (42 U.S.C. Sec. 1315(a)).

(3) Rural health clinic services.

(4) Skilled nursing facilities licensed pursuant to subdivision (c) of Section 1250 of the Health and Safety Code other than those specified in paragraph (2) of subdivision (b).

(5) Intermediate care facilities for the developmentally disabled licensed pursuant to subdivision (e), (g), or (h) of Section 1250 of the Health and Safety Code, or facilities providing continuous skilled nursing care to developmentally disabled individuals pursuant to the pilot project established by Section 14495.10.

(6) Payments to facilities owned or operated by the State Department of Mental Health or the State Department of Developmental Services.

(7) Hospice services.

(8) Contract services, as designated by the director pursuant to subdivision (f).

(9) Payments to providers to the extent that the payments are funded by means of a certified public expenditure or an intergovernmental transfer pursuant to Section 433.51 of Title 42 of the Code of Federal Regulations.

(10) Services pursuant to local assistance contracts and interagency agreements to the extent the

funding is not included in the funds appropriated to the department in the annual Budget Act.

(11) Payments to Medi-Cal managed care plans pursuant to Section 4474.5 for services to consumers transitioning from Agnews Developmental Center into the Counties of Alameda, San Mateo, and Santa Clara pursuant to the Plan for the Closure of Agnews Developmental Center.

(12) Breast and cervical cancer treatment provided pursuant to Section 14007.71 and as described in paragraph (3) of subdivision (a) of Section 14105.18 or Article 1.5 (commencing with Section 104160) of Chapter 2 of Part 1 of Division 103 of the Health and Safety Code.

(13) The Family Planning, Access, Care, and Treatment (Family PACT) Waiver Program pursuant to Section 14105.18.

(14) Small and rural hospitals, as defined in Section 124840 of the Health and Safety Code.

(e) Subject to the exemptions listed in subdivision (d), the payment reductions required by paragraph (1) of subdivision (b) shall apply to the benefits rendered by any provider who may be authorized to bill for provision of the benefit, including, but not limited to, physicians, podiatrists, nurse practitioners, certified nurse midwives, nurse anesthetists, and organized outpatient clinics.

(f) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2

of the Government Code, the department may implement and administer this section by means of provider bulletins, or similar instructions, without taking regulatory action.

(g) The reductions described in this section shall apply only to payments for benefits when the General Fund share of the payment is paid with funds directly appropriated to the department in the annual Budget Act, and shall not apply to payments for benefits paid with funds appropriated to other departments or agencies.

(h) The department shall promptly seek any necessary federal approvals for the implementation of this section. To the extent that federal financial participation is not available with respect to any payment that is reduced pursuant to this section, the director may elect not to implement such reduction.

* * *

SEC. 57. Section 14166.245 of the Welfare and Institutions Code is amended to read:

14166.245. (a) The Legislature finds and declares that the state faces a fiscal crisis that requires unprecedented measures to be taken to reduce General Fund expenditures to avoid reducing vital government services necessary for the protection of the health, safety, and welfare of the citizens of the State of California.

(b)(1) Notwithstanding any other provision of law, except as provided in Article 2.93 (commencing

with Section 14091.3), for hospitals that receive Medi-Cal reimbursement from the State Department of Health Care Services and that are not under contract with the State Department of Health Care Services pursuant to Article 2.6 (commencing with Section 14081) of Chapter 7 of Part 3 of Division 9, the amounts paid as interim payments for inpatient hospital services provided on and after July 1, 2008, shall be reduced by 10 percent.

(2)(A) Beginning on October 1, 2008, amounts paid that are calculated pursuant to paragraph (1) shall not exceed the applicable regional average per diem contract rate for tertiary hospitals and for all other hospitals established as specified in subparagraph (C), reduced by 5 percent, multiplied by the number of Medi-Cal covered inpatient days for which the interim payment is being made.

(B) This paragraph shall not apply to small and rural hospitals specified in Section 124840 of the Health and Safety Code, or to hospitals in open health facility planning areas that were open health facility planning areas on October 1, 2008, unless either of the following apply:

(i) The open health facility planning area at any time on or after July 1, 2005, was a closed health facility planning area as determined by the California Medical Assistance Commission.

(ii) The open health facility planning area has three or more hospitals with licensed general acute care beds.

(C)(i) For purposes of this subdivision and subdivision (c), the average regional per diem contract rates shall be derived from unweighted average contract per diem rates that are publicly available on June 1 of each year, trended forward based on the trends in the California Medical Assistance Commission's Annual Report to the Legislature. For tertiary hospitals, and for all other hospitals, the regional average per diem contract rates shall be based on the geographic regions in the California Medical Assistance Commission's Annual Report to the Legislature. The applicable average regional per diem contract rates for tertiary hospitals and for all other hospitals shall be published by the department on or before October 1, 2008, and these rates shall be updated annually for each state fiscal year and shall become effective each July 1, thereafter. Supplemental payments shall not be included in this calculation.

(ii) For purposes of clause (i), both the federal and nonfederal share of the designated public hospital cost-based rates shall be included in the determination of the average contract rates by multiplying the hospital's interim rate, established pursuant to Section 14166.4 and that is in effect on June 1 of each year, by two.

(iii) For the purposes of this section, a tertiary hospital is a children's hospital specified in Section 10727, or a hospital that has been designated as a Level I or Level II trauma center by the Emergency Medical Services Authority established pursuant to Section 1797.1 of the Health and Safety Code.

(D) For purposes of this section, the terms "open health facility planning area" and "closed health facility planning area" shall have the same meaning and be applied in the same manner as used by the California Medical Assistance Commission in the implementation of the hospital contracting program authorized in Article 2.6 (commencing with Section 14081).

(c)(1) Notwithstanding any other provision of law, for hospitals that receive Medi-Cal reimbursement from the State Department of Health Care Services and that are not under contract with the State Department of Health Care Services, pursuant to Article 2.6 (commencing with Section 14081), the reimbursement amount paid by the department for inpatient services provided to Medi-Cal recipients for dates of service on and after July 1, 2008, shall not exceed the amount determined pursuant to paragraph (3).

(2) For purposes of this subdivision, the reimbursement for inpatient services includes the amounts paid for all categories of inpatient services allowable by Medi-Cal. The reimbursement includes the amounts paid for routine services, together with all related ancillary services.

(3) When calculating a hospital's cost report settlement for a hospital's fiscal period that includes any dates of service on and after July 1, 2008, the settlement for dates of service on and after July 1, 2008, shall be limited to the lesser of the following:

(A) Ninety percent of the hospital's audited allowable cost per day for those services multiplied by the number of Medi-Cal covered inpatient days in the hospital's fiscal year on or after July 1, 2008.

(B) Beginning for dates of service on and after October 1, 2008, the applicable average regional per diem contract rate established as specified in subparagraph (A) of paragraph (2) of subdivision (b), reduced by 5 percent, multiplied by the number of Medi-Cal covered inpatient days in the hospital's fiscal year, or portion thereof. This subparagraph shall not apply to small and rural hospitals specified in Section 124840 of the Health and Safety Code, or to hospitals in open health facility planning areas that were open health facility planning areas on July 1, 2008, unless either of the following apply:

(i) The open health facility planning area at any time on or after July 1, 2005, was a closed health facility planning area as determined by the California Medical Assistance Commission.

(ii) The open health facility planning area has more than three hospitals with licensed general acute care beds.

(d) Except as provided in Article 2.93 (commencing with Section 14091.3), hospitals that participate in the Selective Provider Contracting Program pursuant to Article 2.6 (commencing with Section 14081) and designated public hospitals under Section 14166.1, except Los Angeles County Martin Luther King, Jr./Charles R. Drew Medical Center and

Tuolumne General Hospital, shall be exempt from the limitations required by this section.

(e) Notwithstanding the rulemaking provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the director may implement and administer this section by means of provider bulletins, or other similar instructions, without taking regulatory action.

(f) The director shall promptly seek all necessary federal approvals in order to implement this section, including necessary amendments to the state plan.

(g) Notwithstanding any other provision of this section, small and rural hospitals, as defined in Section 124840 of the Health and Safety Code, shall be exempt from the payment reductions set forth in this section for dates of service on and after November 1, 2008.

(h) For hospitals that are subject to clauses (i) and (ii) of subparagraph (B) of paragraph (2) of subdivision (b) and that choose to contract pursuant to Article 2.6 (commencing with Section 14081), the California Medical Assistance Commission shall negotiate rates taking into account factors specified in Section 14083.

(i)(1) In January 2010 and in January 2011, the department and the California Medical Assistance Commission shall submit a written report to the policy and fiscal committees of the Legislature on the

implementation and impact of the changes made by this section, including, but not limited to, the impact of those changes on the number of hospitals that are contract and noncontract, patient access, and cost savings to the state.

(2) On or before January 1, 2012, the department, in consultation with the California Medical Assistance Commission, shall report on the implementation of this section. The report shall include, but not be limited to, information and analyses addressing patient access, capacity and needs within the health facility planning area, reimbursement of hospital costs, changes in the number of open and closed health facility planning areas, the impact of this section on the extent of hospital contracting, and fiscal impact on the state.

(j) This section shall remain in effect only until January 1, 2013, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2013, deletes or extends that date.

* * *

SEC. 76. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make the necessary statutory changes to implement the Budget Act of 2008 at the earliest possible time, it is necessary that this act take effect immediately.

Senate Bill No. 6

CHAPTER 13

An act to amend Sections 4639.5, 4640.6, 11453, 12201, 12305.1, and 12306.1 of, and to add Sections 11450.02 and 12200.019 to, and to add and repeal Section 12200.018 of the Welfare and Institutions Code, relating to human services, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor February 20, 2009.
Filed with Secretary of State February 20, 2009.]

LEGISLATIVE COUNSEL'S DIGEST

SB 6, Ducheny. Human services.

* * *

Existing law provides for the county-administered In-Home Supportive Services (IHSS) program, under which qualified aged, blind, and disabled persons are provided with services in order to permit them to remain in their own homes and avoid institutionalization.

Existing law establishes the federal Medicaid program, which is administered by each state. California's version of this program is the Medi-Cal program, which is administered by the State Department of Health Services and under which qualified low-income persons receive health care benefits.

Existing law provides for the payment of a supplementary benefit under the IHSS program to any eligible aged, blind, or disabled person who is

receiving Medi-Cal personal care services and who would otherwise be deemed a categorically needy recipient under the IHSS program.

This bill would limit this supplementary payment to individuals who received Medi-Cal personal care services before July 1, 2009, who continue to receive those services, unless a specified notice is made by the Director of Finance to the Joint Legislative Budget Committee, in accordance with a designated section of the Government Code.

Existing law provides that when any increase in provider wages or benefits is negotiated or agreed to by a public authority or nonprofit consortium, the county shall use county-only funds for the state and county share of any increase in the program, unless otherwise provided in the Budget Act or appropriated by statute.

Existing law establishes a formula with regard to provider wages or benefits increases negotiated or agreed to by a public authority or nonprofit consortium, and specifies the percentages required to be paid by the state and counties, beginning with the 2000-01 fiscal year, with regard to the nonfederal share of any increases.

This bill, notwithstanding the existing formula, would limit state participation to a total cost of wages up to $9.50 per hour and individual health benefits up to $0.60 per hour, commencing July 1, 2009, unless a specified notice is made by the Director of Finance to the Joint Legislative Budget Committee,

in accordance with a designated section of the Government Code.

This bill would authorize the State Department of Social Services to implement the changes made by this bill relating to the IHSS program through all-county letters or similar instructions from the director, pending the adoption of emergency regulations.

The California Constitution authorizes the Governor to declare a fiscal emergency and to call the Legislature into special session for that purpose. The Governor issued a proclamation declaring a fiscal emergency, and calling a special session for this purpose, on December 19, 2008.

This bill would state that it addresses the fiscal emergency declared by the Governor by proclamation issued on December 19, 2008, pursuant to the California Constitution.

This bill would declare that it is to take effect immediately as an urgency statute.

The people of the State of California do enact as follows:

* * *

SEC. 9. Section 12306.1 of the Welfare and Institutions Code is amended to read:

12306.1. (a) When any increase in provider wages or benefits is negotiated or agreed to by a public authority or nonprofit consortium under Section 12301.6, then the county shall use county-only

funds to fund both the county share and the state share, including employment taxes, of any increase in the cost of the program, unless otherwise provided for in the annual Budget Act or appropriated by statute. No increase in wages or benefits negotiated or agreed to pursuant to this section shall take effect unless and until, prior to its implementation, the department has obtained the approval of the State Department of Health Care Services for the increase pursuant to a determination that it is consistent with federal law and to ensure federal financial participation for the services under Title XIX of the federal Social Security Act, and unless and until all of the following conditions have been met:

(1) Each county has provided the department with documentation of the approval of the county board of supervisors of the proposed public authority or nonprofit consortium rate, including wages and related expenditures. The documentation shall be received by the department before the department and the State Department of Health Care Services may approve the increase.

(2) Each county has met department guidelines and regulatory requirements as a condition of receiving state participation in the rate.

(b) Any rate approved pursuant to subdivision (a) shall take effect commencing on the first day of the month subsequent to the month in which final approval is received from the department. The

department may grant approval on a conditional basis, subject to the availability of funding.

(c) The state shall pay 65 percent, and each county shall pay 35 percent, of the nonfederal share of wage and benefit increases negotiated by a public authority or nonprofit consortium pursuant to Section 12301.6 and associated employment taxes, only in accordance with subdivisions (d) to (f), inclusive.

(d)(1) The state shall participate as provided in subdivision (c) in wages up to seven dollars and fifty cents ($7.50) per hour and individual health benefits up to sixty cents ($0.60) per hour for all public authority or nonprofit consortium providers. This paragraph shall be operative for the 2000-01 fiscal year and each year thereafter unless otherwise provided in paragraphs (2), (3), (4), and (5), and without regard to when the wage and benefit increase becomes effective.

(2) The state shall participate as provided in subdivision (c) in a total of wages and individual health benefits up to nine dollars and ten cents ($9.10) per hour, if wages have reached at least seven dollars and fifty cents ($7.50) per hour. Counties shall determine, pursuant to the collective bargaining process provided for in subdivision (c) of Section 12301.6, what portion of the nine dollars and ten cents ($9.10) per hour shall be used to fund wage increases above seven dollars and fifty cents ($7.50) per hour or individual health benefit increases, or both. This paragraph shall be operative for the 2001-02 fiscal

year and each fiscal year thereafter, unless otherwise provided in paragraphs (3), (4), and (5).

(3) The state shall participate as provided in subdivision (c) in a total of wages and individual health benefits up to ten dollars and ten cents ($10.10) per hour, if wages have reached at least seven dollars and fifty cents ($7.50) per hour. Counties shall determine, pursuant to the collective bargaining process provided for in subdivision (c) of Section 12301.6, what portion of the ten dollars and ten cents ($10.10) per hour shall be used to fund wage increases above seven dollars and fifty cents ($7.50) per hour or individual health benefit increases, or both. This paragraph shall be operative commencing with the next state fiscal year for which the May Revision forecast of General Fund revenue, excluding transfers, exceeds by at least 5 percent, the most current estimate of revenue, excluding transfers, for the year in which paragraph (2) became operative.

(4) The state shall participate as provided in subdivision (c) in a total of wages and individual health benefits up to eleven dollars and ten cents ($11.10) per hour, if wages have reached at least seven dollars and fifty cents ($7.50) per hour. Counties shall determine, pursuant to the collective bargaining process provided for in subdivision (c) of Section 12301.6, what portion of the eleven dollars and ten cents ($11.10) per hour shall be used to fund wage increases or individual health benefits, or both. This paragraph shall be operative commencing with the next state fiscal year for which the May Revision

forecast of General Fund revenue, excluding transfers, exceeds by at least 5 percent, the most current estimate of revenues, excluding transfers, for the year in which paragraph (3) became operative.

(5) The state shall participate as provided in subdivision (c) in a total cost of wages and individual health benefits up to twelve dollars and ten cents ($12.10) per hour, if wages have reached at least seven dollars and fifty cents ($7.50) per hour. Counties shall determine, pursuant to the collective bargaining process provided for in subdivision (c) of Section 12301.6, what portion of the twelve dollars and ten cents ($12.10) per hour shall be used to fund wage increases above seven dollars and fifty cents ($7.50) per hour or individual health benefit increases, or both. This paragraph shall be operative commencing with the next state fiscal year for which the May Revision forecast of General Fund revenue, excluding transfers, exceeds by at least 5 percent, the most current estimate of revenues, excluding transfers, for the year in which paragraph (4) became operative.

(6) Notwithstanding paragraphs (2) to (5), inclusive, the state shall participate as provided in subdivision (c) in a total cost of wages up to nine dollars and fifty cents ($9.50) per hour and in individual health benefits up to sixty cents ($0.60) per hour. This paragraph shall become operative on July 1, 2009.

(e)(1) On or before May 14 immediately prior to the fiscal year for which state participation is provided under paragraphs (2) to (5), inclusive, of subdivision (d), the Director of Finance shall certify to the Governor, the appropriate committees of the Legislature, and the department that the condition for each subdivision to become operative has been met.

(2) For purposes of certifications under paragraph (1), the General Fund revenue forecast, excluding transfers, that is used for the relevant fiscal year shall be calculated in a manner that is consistent with the definition of General Fund revenues, excluding transfers, that was used by the Department of Finance in the 2000-01 Governor's Budget revenue forecast as reflected on Schedule 8 of the Governor's Budget.

(f) Any increase in overall state participation in wage and benefit increases under paragraphs (2) to (5), inclusive, of subdivision (d), shall be limited to a wage and benefit increase of one dollar ($1) per hour with respect to any fiscal year. With respect to actual changes in specific wages and health benefits negotiated through the collective bargaining process, the state shall participate in the costs, as approved in subdivision (c), up to the maximum levels as provided under paragraphs (2) to (6), inclusive, of subdivision (d).

* * *

SEC. 11. Upon notification from the Director of Finance to the Joint Legislative Budget Committee

pursuant to Section 99030 of the Government Code, Sections 3 and 6 of this act and the amendments to Sections 12305.1 and 12306.1 of the Welfare and Institutions Codes, as contained in Sections 8 and 9 of this act shall be inoperative.

SEC. 12. (a) Notwithstanding the rulemaking provisions of the Administrative Procedure Act, Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, until emergency regulations are filed with the Secretary of State, the State Department of Social Services may implement Sections 8 and 9 of this act through all-county letters or similar instructions from the director. The department shall adopt emergency regulations, as necessary, to implement the specified provisions of this act, no later than December 1, 2010, unless notification of a delay is made to the Chair of the Joint Legislative Budget Committee prior to that date. Under no circumstances shall an adoption of emergency regulations be delayed, or the use of all-county letters or similar instructions be extended, beyond December 1, 2011.

(b) The adoption of regulations implementing the applicable provisions of this act shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. The emergency regulations authorized by this section shall be exempt from review by the Office of Administrative Law. The emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for

filing with the Secretary of State and shall remain in effect for no more than 180 days, by which time the final regulations shall be adopted.

SEC. 13. This act addresses the fiscal emergency declared by the Governor by proclamation on December 19, 2008, pursuant to subdivision (f) of Section 10 of Article IV of the California Constitution.

SEC. 14. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to enable statutory changes to be made in human services provisions at the earliest possible time, it is necessary that this act go into immediate effect.

INDEPENDENT LIVING-TYPE SUPREMACY CLAUSE CASES

I. CALIFORNIA CASES: INJUNCTION ISSUED[1]

1. *Cal. Hosp. Ass'n v. Maxwell-Jolly*, No. CV09-08642 (C.D. Cal.). California Hospital Association challenges 2009 amendments to Cal. Welf & Inst Code §§ 14105.191 and 14166.245, which imposed a statutory freeze on Medicaid reimbursements payments for some services provided by certain hospitals not under contract with the State, and which had the effect of reducing reimbursement to some hospitals by 10%, as preempted by 42 U.S.C. 1396a(a)(13)(A) and 1396a(a)(30)(A). On February 24, 2010, a federal district court enjoined the rate reductions.

Cost of injunction: $2.9 million/month in fiscal year 2009-2010; $4.4 million/month in fiscal year 2010-2011; over $3 million to date (Feb. 24, 2010-Apr. 1, 2010).

2. *Cal. Pharmacists Ass'n v. Maxwell-Jolly*, No. 2:09-cv-00722-CAS (C.D. Cal.); Nos. 09-55532, 09-55365 (9th Cir.). Medicaid providers and others challenge the September 2009 enactment/amendment of Cal. Welf. & Inst. Code §§ 14105.191, 14166.245(b)(2)(A), and 14166.245(c)(3)(B), which reduced Medicaid reimbursement payments to certain fee-for-service providers by 1-5%, as preempted by

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[1] Figures are estimates of total fund expenditures incurred due to injunctions based on best figures currently available to the California Department of Health Services.

42 U.S.C. §§ 1396a(a)(8), 1396a(a)(13)(A), and 1396a(a)(30)(A). This case is the subject of the current petition for certiorari.

Cost of injunction: $7-$8 million/month; in excess of $85 million to date (Mar. 9, 2009/Apr. 6, 2009 through Apr. 1, 2010).

3. *Cota v. Maxwell-Jolly*, No. C 09-3798 SBA (N.D. Cal.). Medicaid beneficiaries challenge California Welfare & Institutions Code §§ 14522.4, 14525.1 and 14526.2, which established new criteria for receipt of Adult Day Health Care (ADHC) services that were to take effect March 1, 2010, as preempted by, *inter alia*, the Medicaid Act, 42 U.S.C. § 1396a(a)(17). On February 24, 2010, a federal district court enjoined the new criteria from taking effect. *Cota v. Maxwell-Jolly*, No. C 09-3798 SBA, 2010 WL 693256 (N.D. Cal Feb. 24, 2010).

Cost of injunction: $839,000 in the current fiscal year; $31.8 million in the 2010-2011 fiscal year.

4. *Dominguez v. Schwarzenegger*, No. CV 09-2306 CW (N.D. Cal.); No. 09-16359 (9th Cir.) (formerly *Yang, Martinez*). Beneficiaries and unions that represent providers of In-Home Supportive Services challenge Cal. Welf & Inst. Code § 12306.1(d)(6), which reduced the State's level of contribution to wages and benefits that counties pay to providers under Medicaid effective July 1, 2009, as preempted by 42 U.S.C. § 1396a(a)(30)(A). This case is the subject of the current petition for certiorari.

Cost of injunction: $6.5 million/month; in excess of $58.5 million to date (July 1, 2009-Apr. 1, 2010).

5. *Indep. Living Ctr. of So. Cal. v. Maxwell-Jolly*, No. 2:08-cv 03315 CAS-MAN (C.D. Cal.); Nos. 08-56061, 08-56422, 08-56554 (9th Cir.). Medicaid providers and others challenge the February 2008 enactment of Cal. Welf. & Inst. Code § 14105.19(b)(1), which reduced by 10% reduction Medicaid reimbursement payments to certain fee-per-service providers, as preempted by 42 U.S.C. § 1396a(a)(30)(A). This case is the subject of a separately-pending petition for certiorari (No. 09-958).

Cost of injunction: no current monthly cost; approximately $332 million to date (through Feb. 1, 2010), plus approximately $70 million in retroactive relief pursuant to the Ninth Circuit's decision in July 2009, for a total in excess of $400 million. (Plaintiffs have indicated that they intend to seek additional retroactive relief that would exceed $250 million, bringing the State's potential liability to over $650 million.)

6. *Indep. Living Ctr. of So. Cal. v. Maxwell-Jolly*, No. 2:09-cv-00382-CAS-MAN (C.D. Cal.); Nos. 09-55692 (9th Cir.). Pharmacies challenge the September 2008 amendment of Cal. Welf & Inst. Code 14105.191(b)(2), which imposed a 1-5% reduction on Medicaid reimbursement payments to pharmaceutical providers, as preempted by 42 U.S.C.

§ 1396a(a)(30)(A). This case is the subject of the current petition for certiorari.

Cost of injunction: $11.54 million/month; $150 million to date (Mar. 1, 2009-Apr. 1, 2010).

7. *Santa Rosa Mem'l. Hosp. v. Maxwell-Jolly*, No. 3:08-cv-05173-SC (N.D. Cal.); No. 09-17633 (9th Cir.). Hospitals challenge the February 2008 amendment of Cal. Welf & Inst. Code §§ 14166.245(b)(1) and (c)(3)(A), which reduced Medicaid reimbursement payments to hospitals not under contract with the State by 10%, as preempted by 42 U.S.C. § 1396a(a)(30)(A). The district court enjoined the reductions on November 18, 2009. *Santa Rosa Mem'l Hosp. v. Maxwell-Jolly*, No. 08-5173 SC, 2009 WL 3925498 (N.D. Cal. Nov. 18, 2009). The appeal of the injunction has been fully briefed in the Ninth Circuit and is awaiting oral argument.

Cost of injunction: $1 million/month; $4.5 million to date (Nov. 18, 2009-Apr. 1, 2010).

8. *V.L. v. Wagner*, No. CV 09-04668 CW (N.D. Cal.); No. 09-17581 (9th Cir.). Medicaid providers and beneficiaries challenge Cal. Welf. & Inst. Code §§ 12309(e) and 12309.2, which provide amended need-based thresholds for receipt of In-Home Supportive Services under Medicaid, as preempted by 42 U.S.C. §§ 1396a(a)(10), 1396a(a)(17), and 42 C.F.R. § 440.230(b). The district court enjoined these statutes on October 23, 2009. *V.L. v. Wagner*, No. C 09-04668 CW, 2009 WL 3486708 (N.D. Cal. Oct. 23, 2009); *see also* 2009 WL 4282079 (N.D. Cal. Nov. 25,

2009). The appeal of the injunction is currently being briefed in the Ninth Circuit.

Cost of injunction: $6.83 million/month; $34.16 million to date (Oct. 23, 2009-Apr. 1, 2010).

II. CALIFORNIA CASES: NO INJUNCTION TO DATE

1. *AIDS Healthcare Found. v. Maxwell-Jolly*, No. CV09-08199 R PLAx (C.D. Cal.). Medicaid provider of prescription drugs challenges the 2009 enactment of Cal. Welf. & Inst. Code § 14105.46, which limits the manner in which certain drugs may be acquired for distribution to Medicaid beneficiaries under the 340B Program, as, *inter alia*, preempted by 42 U.S.C. §§ 1396a(a)(19) and 1396a(a)(30)(A). Briefing is underway in the district court.

2. *Anaheim Mem'l Med. Ctr. v Maxwell-Jolly*, No. 34-2009-80000373 (Cal. Super. Ct. (Sacramento)). Hospital challenges application of Act of Aug. 16, 2004 (SB 1103, § 32), ch. 228, 2004 Cal. Stat. 134-35, which imposed a statutory freeze on Medicaid reimbursement payments to hospitals not under contract with the State, as *inter alia* preempted by 42 U.S.C. §§ 1396a(a)(13)(A) and 1396a(a)(30)(A). This case is stayed during proceedings in another state court case that currently is on appeal.

3. *California Ass'n for Health Servs. at Home v. Shewry*, No. 2:08-cv-07045 CAS (C.D. Cal.). Providers of home health services challenge February and

September 2008 amendments to Cal. Welf. & Inst. Code, §§ 14105.19(a), (b)(1), (b)(2), (c)-(e), 14105.191(a)-(b)(1), (e)-(h), which reduced Medicaid payments to certain providers by 1-10%, as preempted by 42 U.S.C. § 1396a(a)(30)(A). This case is stayed during proceedings in *Indep. Living Ctr. v. Maxwell-Jolly*, No. 2:08-cv 03315 CAS-MAN (C.D. Cal.) (*Indep. Living*).

4. *California Hosp. Ass'n v. Maxwell-Jolly*, No. CV09-3694-CAS-MANx (C.D. Cal.). California Hospital Association challenges the portions of 2008 amendments to Cal. Welf. & Inst. Code §§ 14166.245 and 14091.3 that modified payment rates that Medi-Cal managed care plans pay for emergency and post-stabilization services to hospitals that do not have a contract with a Medi-Cal beneficiary's plan as pre-empted by, *inter alia*, 42 U.S.C. §§ 1396a(a)(13)(A), 1396a(a)(30)(A), and 1396u-2(b).

5. *California Med. Ass'n v. Shewry*, No. BC390126 (Cal. Super. Ct. (Los Angeles)). Medicaid providers, beneficiaries, and others challenge the February 2008 enactment/amendment of Cal. Welf. & Inst. Code §§ 14105.19(b)(1) and 14166.245, which reduced by 10% Medicaid reimbursement payments to certain fee-for-services providers, as preempted by 42 U.S.C. §§ 1396a(a)(8), 1396a(a)(13), 1396a(a)(30)(A), and 42 C.F.R. 447.204. The case is stayed during proceedings in *Indep. Living*.

6. *California Med. Transp. Ass'n v. Shewry*, No. 2:08-cv-07046 (C.D. Cal.). Providers of non-emergency

medical transportation services challenge February and September 2008 amendments to Cal. Welf. & Inst. Code §§ 14105.19(a), (b)(1), (b)(2), (c)-(e) and 14105.191(a)-(b)(1), (e)-(h), which reduced by 1-10% Medicaid reimbursement payments to various providers, as preempted by 42 U.S.C. § 1396a(a)(30)(A). The case is stayed during proceedings in *Indep. Living*.

7. *California Pharm. Ass'n v. Maxwell-Jolly*, No. CV-09-8200 CAS (C.D. Cal.); No. 09-57065 (9th Cir.). Pharmacies challenge a 4% reduction in published average wholesale price (AWP) data as determined by a third party vendor, and enactment/amendment of Cal. Welf. & Inst. Code §§ 14105.45 and 14105.455, alleging that they have the effect of reducing Medicaid reimbursement payments for pharmaceuticals, as preempted by 42 U.S.C. §§ 1396a(a)(5) and 1396a(a)(30)(A). Briefing is underway in the district court.

8. *Centinela Freeman Emergency Med. Assocs. v. Maxwell-Jolly*, No. BC406372 (Cal. Super. Ct. (Los Angeles)). Providers of emergency room services challenge the State's administration of the Medi-Cal Program, with respect to Medicaid reimbursement rates paid for emergency care services, as, *inter alia*, preempted by 42 U.S.C. § 1396a(a)(30)(A). The parties are waiting for oral argument to be rescheduled in state court.

9. *Gray Panthers of San Francisco v. Schwarzenegger*, No. 3:09-cv-02307-PJH (N.D. Cal.);

No. 09-16967 (9th Cir.). Medicaid providers and beneficiaries argued that Cal. Welf. & Inst. Code 14131.10(b)(1), which eliminated Medicaid coverage for certain enumerated services, was preempted by the American Recovery and Reinvestment Act of 2009, H.R. 1, 111th Cong., Pub. L. No. 111-5 (1st Sess. 2009) §§ 5000(a), 5001(f). The district court denied plaintiffs' motion for a preliminary injunction and dismissed the lawsuit. *See Gray Panthers of San Francisco v. Schwarzenegger*, NO. C 09-2307 PJH, 2009 WL 2880555 (N.D. Cal. Sept. 01, 2009); *see also* 2009 WL 2880486 (N.D. Cal. Sept. 01, 2009). Plaintiffs voluntarily dismissed their appeal.

10. *Morales v. Wagner*, Nos. CPF 05-505687, 05-505783, 05-505888 (Cal. Super. Ct. (San Francisco)). An amended petition for writ of mandate, filed on November 4, 2009, asserts a new Supremacy Clause-based challenge to a state statute governing the setting of foster care maintenance rates for children in the foster care system who have developmental disabilities. Petitioners contend that the state statute, Cal. Welf. & Inst. Code § 11464, is preempted by 42 U.S.C. §§ 672(a) and 675(4)(A). District courts around the country disagree on whether the federal statutes at issue create rights enforceable under § 1983, and the Ninth Circuit has not yet reached the issue.

11. *Nat'l Ass'n of Chain Drug Stores, Inc. v. Schwarzenegger*, No. CV09-7097 CAS (C.D. Cal.); No. 09-57051 (9th Cir.). Pharmacies challenge a 4% reduction in published average wholesale price (AWP) data that is developed by a third party vendor, which

has the effect of reducing Medicaid reimbursement payments for pharmaceuticals, as preempted by 42 U.S.C. §§ 1396a(a)(5) and 1396a(a)(30)(A). The district court denied plaintiffs' motion for a preliminary injunction in December 7, 2009. Briefing on the denial of the injunction is underway in the Ninth Circuit.

12. *Putz v. Schwarzenegger*, No. CV-10-0344 (N.D. Cal.). Medicaid recipients and other entities challenge reductions in funding mandated by the legislature and Governor for public authorities that facilitate and support the provision of In-Home Supportive Services under the State's Medicaid program, enacted in July 2009, as preempted by 42 U.S.C. § 1396a(a)(30)(A). Plaintiffs filed their complaint on January 25, 2010, and district court proceedings are underway.

13. *Santa Rosa Mem'l Hosp. v. Maxwell-Jolly*, No. CPF-09-509658 (Cal. Super. Ct. (San Francisco)). Hospitals alleged that the February 2008 enactment/amendment of Cal. Welf. & Inst. Code §§ 14105.19 and 14166.245, which reduced by 10% Medicaid reimbursement payments to, *inter alia*, hospitals not under contract with the State, are preempted by 42 U.S.C. §§ 1396a(a)(8), 1396a(a)(13)(A), 1396a(a)(30)(A), and 1396r-4(a)(1). This case is effectively stayed by agreement of the parties during proceedings in *Santa Rosa Mem'l Hosp. v.Maxwell-Jolly*, No. 3:08-cv-05173-SC (N.D. Cal.); No. 09-17633 (9th Cir.).

III. NONCALIFORNIA CASES

1. *Affiliates, Inc. v. Armstrong*, No. CV-09-149-BLW, 2009 WL 1197341 (D. Idaho Apr. 30, 2009). Plaintiffs challenged a modification in a procedure by which state determines Medicaid reimbursement for support and training services provided to direct caregivers of persons with developmental disabilities as preempted by 42 U.S.C. § 1396a(a)(30)(A). The district court entered a temporary restraining order and held that plaintiffs had asserted a claim that is "actionable under the Supremacy Clause" even though § 1396a(a)(30)(A) does not confer a "substantive" right on providers. *Id.* at *4 (citing *Independent Living Center*). On June 11, 2009, the parties stipulated to a permanent injunction and, on January 22, 2010, the district court entered a permanent injunction.

2. *Ariz. Ass'n of Providers for Persons with Disabilities v. State*, No. 1 CA-CV 09-0167, 219 P.3d 216 (Ariz. Ct. App. 2009). Developmentally disabled Medicaid beneficiaries and service providers challenged 10% reimbursement rate reduction as preempted by 42 U.S.C. § 1396a(a)(30)(A). The Court of Appeal vacated a trial court injunction after holding, based on *Independent Living Center*, that "[t]here is a private cause of action under the Supremacy Clause of the United States Constitution for a violation of Title XIX's network requirements." *Id.* at 228 n.9.

3. *Carter v. Gregoire*, No. C09-5393BHS, ___ F.Supp.2d ___, 2009 WL 2486160 (W.D. Wash. Aug.

12, 2009), *aff'd*, No. 09-35755, 2010 WL 235264 (9th Cir. Jan. 20, 2010); *see also* 2009 WL 1916069 (W.D. Wash. July 1, 2009). Family providers of personal care services challenged change in law requiring family member caregivers to act as independent contractors, instead of home care agency employees, alleging that the law had the effect of reducing the compensation they received for providing such services, as preempted by *inter alia*, 42 U.S.C. §§ 1396a(a)(10)(B), 1396a(a)(23)(A), and 1396a(a)(30)(A). The district court initially granted a temporary restraining order, but then denied plaintiffs' motion for preliminary injunction on the merits (after citing the Supremacy Clause), and the Ninth Circuit affirmed. Plaintiffs voluntarily dismissed case on March 4, 2010.

4. *Christ the King Manor, Inc. v. Sebelius*, No. 9-CV-02007-JEJ (M.D. Pa.). On October 15, 2009, certified nursing facility providers filed a lawsuit challenging the federal government's approval of State Plan Amendments relating to changes to Pennsylvania's methods and standards for payments to nursing facility providers under the State Medicaid Program. Plaintiffs contend that the changes are, *inter alia*, preempted by 42 U.S.C. § 1396a(a)(30)(A). Pennsylvania has advised that briefing is underway in the district court.

5. *Conn. Ass'n of Health Care Facilities, Inc. v. Rell* (D. Conn.). On January 28, 2010, an advocacy group for providers of long-term subacute and rehabilitative services filed a lawsuit challenging

legislative action that it claims freezes Medicaid payments to such facilities at the rates currently in effect until July 1, 2011, effectively reversing increases that the facilities had anticipated. Plaintiffs contend that the freeze is preempted by 42 U.S.C. §§ 1396a(a)(13)(A) and 1396a(a)(30)(A).

6. *G., ex rel., K. v. Hawai'i, Dep't of Human Servs.*, Nos. 08-00551 ACK-BMK, 09-00044 ACK-BMK, 2009 WL 1322354, at *19 n.16 (D. Hawai'i May 11, 2009). Plaintiffs challenged a state requirement that Medicaid beneficiaries enroll with certain health-care entities as a condition of receiving Medicaid benefits in connection with the Hawai'i's managed-care program, as preempted by 42 U.S.C. §§ 1396u-2(a)(1)(A)(i), 1396b (m)(1), 1396u-2(a)(1)(A)(ii), and 1396u-2(b)(5). On May 11, 2009, the district court granted defendants' motion to dismiss these claims finding no "conflict" preemption, after citing *Independent Living Center* for the proposition that plaintiffs had "standing" to bring them. *Id.* at 19 & n.16.

7. *H.S. v. Parkinson*, No. ___ (Kan.). On March 12, 2010, advocacy groups and Medicaid beneficiaries filed a petition for writ of mandamus in the Kansas Supreme Court contending that $10 million in recent Medicaid funding cuts are, *inter alia*, preempted by 42 U.S.C. §§ 1396a(a)(17) and 1396a(a)(30)(A).

8. *Inclusion, Inc. v. Armstrong*, No. 09-CV-00634 BLW (D. Idaho). On December 7, 2009, providers of services to Medicaid beneficiaries with developmental disabilities filed a lawsuit challenging reimbursement

rates that have been in place since 2003 for residential habilitation and developmental therapy services as preempted by 42 U.S.C. § 1396a(a)(30)(A).

9. *Minnesota Pharmacists Ass'n v. Pawlenty*, No. 09-2723 (DWF/RLE), 2010 WL 561473 (D. Minn. Feb. 10, 2010). Pharmacies and beneficiaries seek to enjoin reductions in the reimbursement rates that the State of Minnesota pays pharmacies for brand-name ("single-source") pharmaceutical drugs covered by the State's Medicaid program as preempted by, *inter alia*, 42 U.S.C. § 1396a(a)(30)(A). On February 10, 2010, the district court denied a motion for preliminary injunction, but denied in part a motion for judgment on the pleadings, holding that plaintiffs had stated a claim under the Supremacy Clause. *Id.* at *12-17.

10. *Nat'l Ass'n of Chain Drug Stores, Inc. v. Markell*, No. 09-425 SLR (D. Del.). On June 9, 2009, pharmacies filed a lawsuit challenging a reduction in reimbursement rates for single-source drugs from AWP – 14% to AWP – 16% as preempted by 42 U.S.C. § 1396a(a)(30)(A). Delaware reports that this case settled in August 2009.

11. *Pharmacists Soc'y of the State of N.Y. v. Patterson*, No. 09-CV-01100 (N.D.N.Y.). Pharmacists challenge reduction in reimbursement payments under Medicaid as preempted by 42 U.S.C. § 1396a(a)(30)(A). On January 14, 2010, the district court denied plaintiffs' motion for a preliminary injunction.

12. *Suzman v. Harvey*, No. 07-217, 2008 WL 2945430 (D. Me. Jul. 25, 2008), *report and recommendation adopted by* 2008 WL 3929586 (D. Me. Aug 27, 2008). A recipient of personal care attendant services challenged the state's decision to reduce the hours of services he receives each week under Medicaid as preempted by 42 U.S.C. § 1396a(a)(17)(D). The trial court dismissed plaintiff's claim under 42 U.S.C. § 1983, but declined to dismiss his Supremacy Clause claim. 2008 WL 2945430, at *3-4. Maine advises that the parties subsequently stipulated to dismissal of the case.

13. *Unity Serv. Coord., Inc. v. Armstrong*, No. 09-CV-00639-BLW (D. Idaho). On December 9, 2009, providers of Service Coordination benefits to Medicaid beneficiaries filed a lawsuit challenging a recent (nonstatutory) rate methodology change (adoption of a fee-for-service incremental rate in place of the previously-used bundled daily rate) in the services they provide as preempted by 42 U.S.C. § 1396a(a)(30)(A).

14. *Wash. Health Care Ass'n v. Dreyfus*, No. C09-5395-RBL (W.D. Wash.). On June 30, 2009, the association of for-profit nursing facilities in Washington and several individual facilities filed a lawsuit challenging a scheduled cut in Medicaid payment rates as preempted by 42 U.S.C. § 1396a(a)(30)(A). A federal judge issued a temporary restraining order to prevent the cuts from taking effect. The parties have agreed to put the lawsuit on hold while they try to reach a legislative solution.

15. *Wash. State Pharmacy Ass'n v. Gregoire*, No. C09 5174-BHS, 2009 WL 1259632 (W.D. Wash. Mar. 31, 2009). Pharmacy association challenged six percentage point reduction in Medicaid reimbursement rates as preempted by 42 U.S.C. § 1396a(a)(30)(A). On March 31, 2009, a district court enjoined the rate reductions.

16. *Wash. State Pharmacy Ass'n v. Gregoire*, No. C09-1377-RAJ (W.D. Wash.). On September 29, 2009, a pharmacy association and other entities filed a lawsuit challenging the state's drug-ingredient payment amounts, in the wake of a reduction in AWP as determined by a third party vendor, as preempted by 42 U.S.C. § 1396a(a)(30)(A). On February 10, 2010, the district court entered an order holding that plaintiff has standing to sue under the Supremacy Clause but denying plaintiff's motion for a preliminary injunction.

17. *Women's Hosp. Found. v. Townsend*, No. 07-711-JJB-DLD, 2008 WL 2743284, at *11 (M.D. La. July 10, 2008). Hospital and Medicaid beneficiaries challenge Medicaid reimbursement rates as preempted by 42 U.S.C. § 1396a(a)(30)(A) and Medicaid regulations. The district court held that plaintiffs stated a cause of action under the Supremacy Clause and declined to dismiss the complaint. *Id.* at *11.

Supreme Court, U.S.
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No. 09-1158

IN THE
SUPREME COURT OF THE UNITED STATES

DAVID MAXWELL-JOLLY, DIRECTOR, CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES, PETITIONER,

v.

CALIFORNIA PHARMACISTS ASSOCIATION, ET AL., RESPONDENTS.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF OF RESPONDENTS INDEPENDENT LIVING CENTER OF SOUTHERN CALIFORNIA, INC.; GERALD SHAPIRO, PHARM.D, D/B/A UPTOWN PHARMACY AND GIFT SHOPPE; SHARON STEENE, D/B/A CENTRAL PHARMACY; AND TRAN PHARMACY, INC., D/B/A TRAN PHARMACY IN OPPOSITION

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MAY 24, 2010

PARTIES TO THE PROCEEDING

Petitioner is David Maxwell-Jolly, Director of the Department of Health Care Services, State of California (DHCS).

Respondents in this Opposition brief are Independent Living Center of Southern California, Inc.; Gerald Shapiro, Pharm.D., d/b/a Uptown Pharmacy and Gift Shoppe; Sharon Steen, d/b/a Central Pharmacy; and Tran Pharmacy, Inc., d/b/a Tran Pharmacy, who are the plaintiffs-appellees in Case No. 09-55692, *Independent Living Center of Southern California v. Maxwell-Jolly*.

CORPORATE DISCLOSURE STATEMENT (RULE 29.6)

None of the corporations who were plaintiffs-appellees below in Case No. 09-55692 have a parent corporation and no public corporation owns any stock in these corporations.

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BRIEF IN OPPOSITION

STATEMENT

A. Statutory Framework

1. Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (hereinafter "Medicaid Act"), is a cooperative federal-state program that provides federal financial assistance to participating States to enable them to provide medical treatment for the poor, elderly, and disabled.

A State's participation in Medicaid is voluntary. However, if a State chooses to participate, then it must comply with the Medicaid Act and its implementing regulations. To receive federal funds, States are required to establish and administer their Medicaid programs through individual "state plans for medical assistance" approved by the federal Secretary of Health and Human Services (HHS). 42 U.S.C. § 1396.

The Medicaid Act provides specific requirements for state plans and reimbursement rates, *see* 42 U.S.C. § 1396a(a)(1)-(71), including those set out in § 1396a(a)(30)(A) (hereinafter "Section 30A"), the specific provision at issue in this case. Section 30A requires that a state plan must provide such methods and procedures relating to payments for care and services to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers to ensure that care and services are as available to recipients as is available to the public in the same geographical area.

2. On February 16, 2008, the California Legislature enacted Assembly Bill X3 5 (hereinafter

"AB 5"). AB 5 added § 14105.19 to the Welfare and Institutions Code, which instructed petitioner Director of the Department of Health Care Services, as the state agency which administers California's state Medicaid plan, to cut by ten percent reimbursement rates under the Medi-Cal fee-for-service program to physicians, dentists, pharmacies, adult day health care centers, optometrists, clinics, and other providers. AB 5 provided that the ten percent rate cuts were to go into effect on July 1, 2008. *See* Cal. Welf. & Inst. Code § 14105.19(b)(1) (2008).[1]

The California Legislature subsequently enacted Assembly Bill 1183 (hereinafter "AB 1183"), on September 30, 2008. Section 44 of AB 1183 amended § 14105.19 to make the rate reductions of AB 5, excluding non-contract hospitals, expire on February 28, 2009. Cal. Welf. & Inst. Code § 14105.19(b). Section 45 of AB 1183 added a new § 14105.191 (2009) that, effective March 1, 2009, required a five percent rate cut for pharmacies under Medi-Cal's fee-for-service program. Section 57 of AB 1183 makes the legislative finding that the "state faces a fiscal crisis that requires unprecedented measures to be taken to reduce General Fund expenditures." Pet. App. 210. The Legislature provided that the act would "take effect immediately." Pet. App. 216-17 (§ 76).

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[1] The ten percent cuts of AB 5 were challenged in another case with the same caption. The instant suit does not address the cuts in AB 5.

B. Factual Background

1. The Respondents are an independent living center with more than 5,000 clients or members who are Medi-Cal beneficiaries in the Medi-Cal fee-for-service program, and three Medi-Cal pharmacies with more than 8,000 Medi-Cal beneficiaries. On January 16, 2009, they sued David Maxwell-Jolly, Director of the California Department of Health Care Services, in the United States District Court of the Central District of California to prevent the implementation of AB 1183. Pet. App. 128-29.

The complaint alleged that the action of the State to enact and implement the five percent payment reduction of AB 1183 was void, contrary to and preempted under the Supremacy Clause by the federal quality of services and equal access clauses of Section 30A, due to the fact that the Legislature had enacted AB 1183 without considering—as required by Section 30A—the relevant factors of whether providers could sustain the payment reduction without loss of quality of services and equal access of beneficiaries to quality services; and that irreparable injury in the form of reduction and denial of access to services to Medi-Cal beneficiaries would result. Pet. App. 130.

The relief sought by Respondents was an injunction to prohibit the Director of the Department of Health Care Services from implementing AB 1183. Pet App. 130.

2. On February 27, 2009, the district court granted respondents' motion for injunctive relief. Pet. App. 151.

In holding that respondents could bring their claim under the Supremacy Clause, the district court relied on the Ninth Circuit's decision in *Indep. Living Ctr. of S. California, Inc. v. Shewry*, 543 F.3d 1050 (9th Cir. 2008) *cert. denied*, 129 S. Ct. 2828 (U.S. 2009) (hereinafter "*ILC I*"). In that opinion, the Ninth Circuit stated that "[t]he Supreme Court has repeatedly entertained claims for injunctive relief based on federal preemption, without requiring that the standards for bringing suit under § 1983 be met." The court cited in detail the numerous cases holding that claims for injunctive relief based on federal preemption may be brought absent any express right or cause of action. *Id.* at 1055-1056 (citing, *inter alia*, *City of Burbank v. Lockheed Air Terminal Inc.*, 411 U.S. 624 (1973); *Ray v. Atl. Richfield Co.*, 435 U.S. 151 (1978); and *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983). *Id.* at 1055-1056.

In *ILC I*, the Ninth Circuit also rejected petitioner's argument that a claim of preemption under a federal statute enacted pursuant to Congress' spending power, like the Medicaid Act, should be treated differently. *Id.* at 1059-1062. The Ninth Circuit noted that this Court and other circuits that have addressed the argument flatly rejected it. *Id.* Petitioner's petitions for rehearing, rehearing *en banc* and certiorari for this decision were denied.

The first question of this present petition for certiorari (No. 09-1158) is essentially, therefore, another bite of the same apple, without any change in circumstances or new law cited by petitioner to

justify or explain why the Court should now re-visit and re-review its prior decision to deny certiorari on the facts and legal claims in respect to which certiorari was previously denied, in 2009.

3. In the instant case, the district court concluded that respondents had met their burden of demonstrating that a preliminary injunction should issue to enjoin implementation of AB 1183.

The district court found that respondents demonstrated a likelihood of success on the merits because the Legislature enacted the rate reduction without any consideration of the relevant factors required by Section 30A to be considered—efficiency, economy, quality of care, and equality of access, as well as the effect of providers' costs on those relevant factors—and failed to show any justification other than purely budgetary concerns for rates that substantially deviate from the providers' costs. Pet. App. 139, 143.

Also, it found that respondents demonstrated a substantial likelihood of irreparable harm resulting from implementation of AB 1183, because the cuts would limit Medi-Cal beneficiaries' access to many brand and generic drugs. Pet. App. 144-49. In addition, the evidence established that independent pharmacies represent thirty-three percent of the licensed community pharmacies in California and many of these pharmacies with higher than average costs would be "hard-hit" by the cut, causing a discontinuation or severe reduction in services to Medi-Cal beneficiaries. Pet. App. 148-49.

Weighing the balance of the hardships and the public interest, the district court concluded that the

"significant threat to the health of Medi-Cal recipients" that "reducing payments to health-care service providers will likely cause" outweighed any expected fiscal savings, which the district court noted were unlikely to materialize because "many Medi-Cal beneficiaries will turn to more costly forms of medical care, such as emergency room care." Pet. App. 147 n.7.

On April 3, 2009, the district court denied petitioner's motion to amend, alter, or clarify the preliminary injunction of February 27, 2009. Pet. App. 152.

4. On March 3, 2010, the Ninth Circuit affirmed the district court's issuance of a preliminary injunction. Pet. App. 53. In an unreported decision, the court referenced the reasoning supplied in another case decided that day, *California Pharmacists Ass'n v. Maxwell-Jolly*, 596 F.3d 1098 (9th Cir. 2010) (hereinafter "*California Pharmacists*"), which rejected petitioner's arguments on the likelihood of success on the merits. Pet. App. 54.

Petitioner argued in both *California Pharmacists* and the instant case that while the state Legislature enacted the rate cuts, nevertheless, the Legislature did not need to comply with the mandate of Section 30A. Instead, petitioner contended, only the Department was required to consider the factors set forth in Section 30A. Pet. App. 11.

The Ninth Circuit held in *California Pharmacists* that whichever state body sets the rates must comply with the federal requirements for setting them. The court explained: "[S]uch an approach is

consistent with that of our sister circuits, where in the context of legislative, as opposed to agency, rate-setting, they too have focused on ensuring that the legislative body had information before it so that it could properly consider efficiency, economy, quality of care, and access to services *before* enacting rates." Pet. App. 15-16 (emphasis in original) (citing cases from the Eighth Circuit).

Next, petitioner argued in *California Pharmacists* that the state Legislature did actually consider the factors of Section 30A. The Ninth Circuit upheld the district court's conclusion that the legislative history showed that the Legislature did not in fact consider the Section 30A factors but rather was "concerned solely with budgetary matters." Pet. App. 20.

The Ninth Circuit then reiterated its holding from *Indep. Living Ctr. of S. California, Inc. v. Maxwell-Jolly*, 572 F.3d 644 (9th Cir. 2009)(hereinafter "*ILC II*"), which is consistent with all the courts of appeals to consider the issue, that Section 30A mandates that state Medicaid rate reductions "may not be based solely on state budgetary concerns." 572 F.3d at 659 (citing cases from the Third, Eighth, Ninth, and Tenth Circuits).

Petitioner further argued in *California Pharmacists* that the Department had retained the discretion not to implement the rate cut and that the Department's post-enactment study complied with the requirements of Section 30A. The Ninth Circuit noted that this argument had been waived because it was not raised in petitioner's opening brief, but further rejected the argument on the merits. Pet. App. 22-24.

The court concluded that the Department's contention that it had discretion not to implement the cuts was rebutted by the clear text of the state law as well as the state's published notice announcing that the Department "is mandated" to implement the rate reductions. Pet. App. 26-28.

5. In the instant ILC Plaintiffs case, petitioner did not contest, at the preliminary injunction hearing, nor in his appeal briefs, that the Legislature did not in fact consider the relevant quality and equal access factors of Section 30A, in enacting AB 1183. Pet. App. 141, 54-55. At oral argument at the Ninth Circuit, petitioner did assert, for the first time, that the legislature had considered the Section 30A factors with regard to pharmacies. Yet, the only evidence proffered by petitioner was a comment on the May 30, 2008 agenda of Assembly Budget Subcommittee stating: "Dec. 2007 Myers and Stauffer study found that current Medi-Cal drug pricing averages around 5 percent over cost," (Pet. App. 54-55), the veracity of which comment was challenged by the ILC Plaintiffs at the oral argument. The Ninth Circuit, without ruling on the veracity issue, noted that petitioner did not even argue in his briefing, in either the district court or on appeal, that the citation to a study is sufficient to comply with Section 30A. *Id.* The Ninth Circuit concluded that a one-sentence citation to the May 30, 2008 agenda "does not show adequate consideration of the § 30(A) factors." *Id.* at 55-56.

In addition, the Ninth Circuit found that the cited study did not demonstrate that the rate cut complied with Section 30A. The court noted that while the study addressed costs, "it is bereft of any

analysis of the remaining § 30(A) factors – efficiency, economy, quality, and access to care." Pet. App. 56. The study indicated that in setting an appropriate reimbursement formula, costs and market dynamics should be "balanced with the need to maintain sufficient access to services for Medi-Cal recipients throughout the state." *Id.* Further, the study instructed that the rate setter should "consider issues of access to services." *Id.* The study also did not address whether "the costs observed are reflective of providers operating in the most efficient manner possible." *Id.* The Ninth Circuit therefore affirmed the district court's holding that respondents were likely to succeed on their claim that the rates were not set in compliance with Section 30A.

The Ninth Circuit similarly found that the district court did not abuse its discretion in holding that respondents had demonstrated irreparable harm. The appeals court explained: "The district court concluded that even if, on average pharmacies would be compensated above their acquisition costs, the Director had not refuted Plaintiffs' showing that many brand and generic drugs would be reimbursed at a level below cost, limiting Medi-Cal patients' access to those drugs." *Id.*

REASONS THE PETITION SHOULD BE DENIED

I. *CERTIORARI* SHOULD BE DENIED ON THE FIRST QUESTION BECAUSE THERE IS NO DIVISION IN THE LOWER COURTS AND THE DECISION BELOW IS A CORRECT APPLICATION OF THIS COURT'S SETTLED SUPREMACY CLAUSE JURISPRUDENCE

A. The Courts Of Appeals Have Uniformly Reached The Same Conclusion As The Panel Below

While petitioner's previous petitions have alleged conflict in the courts of appeals, the present petition contains no such claim. To the contrary, the present petition seeks review based on the harmonious interpretation of law among the Ninth, D.C., Fifth and Eighth Circuits. Pet. 27. Indeed, every court of appeals is in accord with the Ninth Circuit's holding that a federal court may resolve, on the merits, a claim that a plaintiff will be injured unless injunctive or declaratory relief is issued to enjoin a preempted state law.

The unanimity among courts of appeals follows naturally from the clarity of the Court's preemption decisions, such as *Verizon Maryland, Inc. v. Pub. Serv. Comm'n of Maryland*, 535 U.S. 635 (2002). Petitioner's assertion that the Court has failed to address pertinent questions of law is rebutted by the widespread agreement among courts of appeals regarding the appropriate standards for permitting a preemption claim.

Verizon established that a statutory cause of action is not needed for a preemption claim. Any change in this holding would impact a wide range of preemption claims, including those frequently brought by businesses. Indeed, "most federal statutes that are at issue in ... preemption cases do not create an express private cause of action for injunctive relief against state officers." David Sloss, *Constitutional Remedies for Statutory Violations*, 89 Iowa L. Rev. 355, 406-7 (2004).

Petitioner suggests that preemption claims under Spending Clause statutes should be treated differently, but petitioner does not cite a single case that so holds. And there is no basis in the text of the Constitution for differentiating the Spending Clause from any other constitutional provision under which Congress legislates. Samuel R. Bagenstos, *Spending Clause Litigation in the Roberts Court*, 58 Duke L.J. 345, 392-93 (2008).

A change in the standards for preemption would have widespread implications, reducing the primacy of federal law in our system of government. As Justice Kennedy has observed, "the whole jurisprudence of preemption" is of vital importance to "maintaining the federal balance." *United States v. Lopez*, 514 U.S. 549, 577 (1995) (Kennedy, J., concurring).

Petitioner provides citations for the decisions of the D.C., First, Fifth, and Eighth Circuits that have permitted preemption claims to be considered on the merits in the context of Spending Clause statutes. Pet. 27. Petitioner has previously conceded in its earlier petition that in cases brought under non-

Spending Clause statutes, several other Circuits have permitted preemption claims "regardless of whether the federal statutes create privately enforceable rights," giving as examples cases from the Second, Third, and Tenth Circuits. Petition in *ILC II* at 22, n.6.

Indeed, the Tenth Circuit held that a "party may bring a claim under the Supremacy Clause that a local enactment is preempted even if the federal law at issue does not create a private right of action." *Qwest Corp. v. City of Santa Fe, New Mexico*, 380 F.3d 1258, 1266 (10th Cir. 2004). Accord *Burgio & Campofelice, Inc. v. New York State Dept. of Labor*, 107 F.3d 1000, 1006 (2d Cir. 1997). The Third Circuit similarly concluded that "a state or territorial law can be unenforceable as preempted by federal law even when the federal law secures no individual substantive rights for the party arguing preemption." *St. Thomas--St. John Hotel & Tourism Ass'n, Inc. v. Gov't of U.S. Virgin Islands*, 218 F.3d 232, 241 (3d Cir. 2000).

Moreover, the Fourth, Sixth, Seventh and Eleventh Circuits have also held that preemption claims do not depend upon a cause of action in the preempting federal statute. The Fourth Circuit stated: "we need not inquire into whether [the federal statute] provides a cause of action" for a preemption claim. *Verizon Maryland, Inc. v. Global NAPS, Inc.*, 377 F.3d 355, 368-369 (4th Cir. 2004). The Seventh Circuit rejected the argument advanced by petitioner in this case that *Gonzaga Univ. v. Doe*, 536 U.S. 273 (2002), is applicable to a preemption claim. *Illinois Ass'n of Mortg. Brokers v. Office of*

Banks & Real Estate, 308 F.3d 762, 765 (7th Cir. 2002). The Sixth Circuit held that there is "a cause of action for prospective injunctive relief" for federal preemption claims. *GTE N., Inc. v. Strand*, 209 F.3d 909, 916 (6th Cir. 2000), *cert. denied*, 531 U.S. 957 (2000). Finally, the Eleventh Circuit held *en banc* that, apart from any express cause of action available under the statute, "[f]ederal courts must resolve the question of whether a public service commission's order violates federal law and any other federal question." *BellSouth Telecommunications, Inc. v. MCImetro Access Transmission Services, Inc.*, 317 F.3d 1270, 1278 (11th Cir. 2003) (citing *Verizon Maryland, Inc.*, 535 U.S. 635); *see also id.* at 1296 (Tjoflat, J., dissenting on other grounds) ("litigants may assert a private right of action for preemption under the Supremacy Clause").

B. The Decision Below, Like The Decisions Of All The Other Courts Of Appeals, Followed Numerous Precedents Of This Court Permitting Preemption Claims To Enjoin State Law, Including In Cases Involving Spending Clause Statutes

1. This Court has long permitted private parties to obtain declaratory and injunctive relief to prevent injury from state laws that are preempted by federal law. In *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983), employers sought a declaration that a New York law was preempted by a federal statute providing no cause of action. The Court unanimously reached the merits of the employers' preemption claim. It explained:

> A plaintiff who seeks injunctive relief from state regulation, on the ground that such regulation is pre-empted by a federal statute which, by virtue of the Supremacy Clause of the Constitution, must prevail, thus presents a federal question which the federal courts have jurisdiction under 28 U.S.C. § 1331 to resolve.

463 U.S. at 96 n.14.

Subsequently, this Court unanimously reaffirmed the availability of injunctive relief on the basis of federal preemption. In *Verizon Maryland, Inc. v. Pub. Serv. Comm'n of Maryland*, 535 U.S. 635 (2002), the Court again sustained the jurisdiction of the federal courts to hear claims that state conduct (there, an order of the public service commission) was preempted by federal law. In *Verizon*, the state commission argued that Verizon's preemption claim could not proceed, because the federal Telecommunications Act "does not create a private cause of action to challenge the Commission's order." 535 U.S. at 642. The Court dismissed this argument, stating:

> We need express no opinion on the premise of this argument. "It is firmly established in our cases that the absence of a valid (as opposed to arguable) cause of action does not implicate subject-matter jurisdiction, *i.e.*, the courts' statutory or constitutional power to adjudicate the case." As we have said, "the district court has jurisdiction if the right of the petitioners to recover under their complaint will be sustained if the Constitution and laws of the United States are given one construction and will be defeated if they

> are given another, unless the claim clearly appears to be immaterial and made solely for the purpose of obtaining jurisdiction or where such a claim is wholly insubstantial and frivolous."

Id. at 642-643 (citations and some quotation marks omitted).

As in *Shaw* and *Verizon*, respondents seek declaratory and injunctive relief against an allegedly preempted state law. Respondents' entitlement to relief will unquestionably depend on the construction of a federal statute. Petitioner does not argue that the claim is immaterial or wholly insubstantial and frivolous. The Ninth Circuit dutifully followed *Shaw* and *Verizon* in reaching the merits of the preemption claim.

It is true that these cases speak in terms of jurisdiction, rather than in terms of a cause of action. But petitioner does not dispute the existence of a federal cause of action to enforce the Supremacy Clause. Indeed, petitioner himself conceded below that there were "circumstances under which a party may properly seek relief under the Supremacy Clause." C.A. *ILC I* Pet. Opening Br. 6. This sensible concession is in accord with the repeated and consistent actions of this Court in adjudicating preemption claims on the merits even in the absence of an express or implied statutory cause of action. It is also consistent with the understandings of leading federal courts treatises. *See* Richard H. Fallon, Jr., Daniel J. Meltzer, & David L. Shapiro, *Hart & Wechsler's The Federal Courts & The Federal System* 903 (5th ed. 2003); 13D Charles A. Wright, Arthur R.

Miller & Edward H. Cooper, *Federal Practice and Procedure* § 3566 (3d ed. 2008).[2]

2. Petitioner nonetheless argues that respondents' claim should be dismissed, because the federal statute at issue in this case, Medicaid, is a Spending Clause statute. Pet. 26-27. That assertion is contrary to this Court's recent practice.

This Court has repeatedly adjudicated claims by private parties asserting preemption by virtue of the Medicaid statute and other federal spending statutes. In *Arkansas Dept. of Health & Human Services v. Ahlborn*, 547 U.S. 268 (2006), a Medicaid recipient sought a declaratory judgment that a state law was preempted by the Medicaid Act, and this Court unanimously agreed. In *Pharm. Research & Mfrs. of Am. v. Walsh*, 538 U.S. 644 (2003), drug makers also brought an action asserting preemption of a state law under the Act. A plurality of four Justices concluded on the merits that the state law was not preempted, while three Justices argued in dissent that the state law was indeed preempted.[3]

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[2] The Second and Fifth Circuits have identified the Supremacy Clause itself as the basis of a cause of action for preemption claims. *See Burgio & Campofelice, Inc. v. New York State Dept. of Labor*, 107 F.3d 1000, 1006 (2d Cir. 1997); *Planned Parenthood of Houston & Se. Tex. v. Sanchez*, 403 F.3d 324, 333 (5th Cir. 2005).

[3] Justice Thomas's concurrence suggested that the Court might want to consider "whether Spending Clause legislation can be enforced by third parties in the absence of a private right of action." *Pharm. Research & Mfrs. of Am. v. Walsh*, 538 U.S. 644, 683 (2003) (Thomas, J., concurring in judgment). Justice

(Footnote continued on following page)

Furthermore, petitioner's argument appears to rely on the assumption that federal Spending Clause statutes cannot preempt state statutes under the Supremacy Clause. But that is contrary to a host of this Court's holdings. *See, e.g.*, *Dalton v. Little Rock Family Planning Services*, 516 U.S. 474, 476 (1996) (per curiam) (preemption under Medicaid); *Blum v. Bacon*, 457 U.S. 132, 138 (1982); *CSX Transp., Inc. v. Easterwood*, 507 U.S. 658, 663 (1993); *Lawrence County v. Lead-Deadwood Sch. Dist. No. 40-1*, 469 U.S. 256, 269-270 (1985); *see also Pennsylvania Prot. & Advocacy, Inc. v. Houstoun*, 228 F.3d 423, 428 (3d Cir. 2000) (Alito, J.).[4] In essence, petitioner makes a policy argument against enforcement of the Medicaid statute, but this policy argument has no basis in law.

Scalia concurred separately, proposing initial enforcement by the federal government. *Id.* at 675 (Scalia, J., concurring in judgment). Nevertheless, both Justices joined without reservation the Court's subsequent decision in *Arkansas Dept. of Health & Human Services v. Ahlborn*, 547 U.S. 268 (2006), resolving a private action asserting preemption under Medicaid.

[4] Every court of appeals to consider the argument that Medicaid as a whole is unenforceable (arising largely in the context of suits under § 1983) because of its nature as Spending Clause legislation, has rejected that argument as contrary to extensive Supreme Court precedent. *Missouri Child Care Ass'n v. Cross*, 294 F.3d 1034, 1041 (8th Cir. 2002); *Antrican v. Odom*, 290 F.3d 178, 188 (4th Cir. 2002); *Westside Mothers v. Haveman*, 289 F.3d 852, 860 (6th Cir. 2002), *cert. denied*, 537 U.S. 1045 (2002); *Frazar v. Gilbert*, 300 F.3d 530, 550 (5th Cir. 2002) *rev'd sub nom. Frew ex rel. Frew v. Hawkins*, 540 U.S. 431 (2004).

Indeed, this Court has consistently held that the Eleventh Amendment is not a bar to private parties seeking prospective injunctive relief against state officials to enforce Medicaid and other Spending Clause statutes because such suits are necessary in order to vindicate the Supremacy Clause. *See Frew ex rel. Frew v. Hawkins*, 540 U.S. 431, 437 (2004) (Medicaid); *Edelman v. Jordan*, 415 U.S. 651 (1974) (Aid to the Aged, Blind, and Disabled).

3. Petitioner also suggests (Pet. 37) that because of the oversight role of the federal government in the Medicaid program, a preemption claim should not be permitted. As this Court explained in *Verizon*, a preemption claim may proceed as long as the statute "does not *divest* the district courts of their authority" under federal question jurisdiction to review the state's "compliance with federal law." *Verizon Maryland, Inc.*, 535 U.S. at 642 (emphasis in original). There is nothing in the text or structure of the Medicaid Act that divests the courts of their authority to resolve a preemption claim. The federal government's ability to withhold federal funds does not preclude other federal remedies. *Rosado v. Wyman*, 397 U.S. 397 (1970). *See also Blessing v. Freestone*, 520 U.S. 329, 346-348 (1997); *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498, 521 (1990).

4. Preemption claims such as respondents' are consistent with the voluntary nature of states' participation in federal spending programs.

Petitioner's assertion of a "sovereign right to choose not to comply," with such statutes, Pet. in *ILC I* at 32 (April 1, 2009), is erroneous. States have a sovereign right to choose not to participate in

federal programs and to choose not to take federal monies. But once they have made those choices, the State "must comply with [the federal statute's] mandates." *Winkelman ex rel. Winkelman v. Parma City Sch. Dist.*, 550 U.S. 516, 520 (2007).

Although petitioner complains of the cost to comply with federal law, (*see*, Pet. Br. 28), the federal government matches or exceeds state dollars for Medi-Cal. The federal government paid half of Medi-Cal expenditures prior to October 2008, and will pay more than half for the period of October 2008 to December 2010 pursuant to the American Recovery and Reinvestment Act of 2009 (hereinafter "ARRA"), Pub. L. No. 111-5, 123 Stat. 115. Under ARRA, the federal government is expected to spend over $11 billion on Medi-Cal for that period. Kaiser Commission on Medicaid and the Uninsured, *American Recovery and Reinvestment Act (AARA): Medicaid and Health Care Provisions* (Mar. 2009), at http://www.kff.org/medicaid/upload/7872.pdf. In return for this infusion of billions of federal dollars to provide health insurance for California residents, it is fitting that the state be required to comply with federal law.

Moreover, this is not the first time the Ninth Circuit has recognized this cause of action. To the contrary, the court of appeals and many other courts of appeals expressly reached the same conclusion long ago. As petitioner himself acknowledged below, the Ninth Circuit "has recognized that 'the Supremacy Clause creates an implied right of action for injunctive relief against state officers who are threatening to violate the federal Constitution or laws.' " C.A. *ILC I* Pet. Opening Br. 5-6 (quoting

Guar. Nat. Ins. Co. v. Gates, 916 F.2d 508, 512 (9th Cir. 1990)); *see also Bernhardt v. Los Angeles County*, 339 F.3d 920, 929 (9th Cir. 2003); *Bud Antle, Inc. v. Barbosa*, 45 F.3d 1261, 1269 (9th Cir. 1994).

5. Petitioner argues that under the Ninth Circuit's ruling in *ILC I*, any alleged conflict between federal and state law is sufficient to "enjoin state conduct," thereby opening "the door to a flood of lawsuits." Pet. 27. Yet, petitioner refutes his own argument by citing a recent California case applying *ILC I* in which the district court dismissed the Supremacy Clause claim, finding no preemption of state law. Pet. 28 (citing *Gray Panthers of San Francisco v. Schwarzenegger*, C 09-2307 PJH, 2009 WL 2880555 (N.D. Cal. Sept. 1, 2009)). Similarly, in other Supremacy Clause cases involving Spending Clause statutes in which the court found no conflict between federal and state law, claims have been dismissed in accordance with this Court's clear directions for preemption cases. *See, e.g., Equal Access for El Paso, Inc. v. Hawkins*, 562 F.3d 724 (5th Cir. 2009).

C. There Is No Basis For Petitioner's Assertion That A Preemption Claim Must Satisfy The Standards Of an Implied Private Right of Action and 42 U.S.C. § 1983

Petitioner suggests that respondents' preemption claim should be dismissed because it does not meet the standards for a cause of action under an implied private right of action and under 42 U.S.C. § 1983 ("Section 1983"). Pet. 27. This Court has never

utilized either standard for a preemption claim, and indeed, petitioner cites no case which has so ruled.

1. Petitioner suggests that Congress did not intend to create a private remedy under an implied private right of action. Pet. 27. The remedy in this case is a declaration that federal law preempts state law and an injunction preventing enforcement of a preempted state law. This remedy is supplied by the Supremacy Clause, not an implied private right of action, and does not depend upon an express declaration by Congress. As this Court has explained, "the existence of conflict cognizable under the Supremacy Clause does not depend on express congressional recognition that federal and state law may conflict." *Crosby v. Nat'l Foreign Trade Council*, 530 U.S. 363, 388 (2000). Thus, the cases cited by petitioner requiring express statements by Congress to create an implied private right of action are simply inapposite to respondents' preemption claim.

Indeed, *Verizon* rejected the assertion that a district court could not reach the merits of a preemption claim unless the plaintiff had demonstrated a statutory cause of action. *Verizon Maryland, Inc. v. Pub. Serv. Comm'n of Maryland*, 535 U.S. 635, 642 (2002). Dutifully following *Verizon*, the Fourth Circuit rejected the argument advanced by petitioner in the instant case (Pet. 17) that *Cort v. Ash*, 422 U.S. 66 (1975), applies to a preemption claim. *Verizon Maryland, Inc.*, 377 F.3d at 368-369. As noted *supra*, a claim under the Supremacy Clause is not dependent upon a statutory cause of action, either express or implied.

2. Section 1983 is an express cause of action to enforce statutory and constitutional rights that provides various remedies against individuals acting under color of state law and municipal corporations. It does not supplant or repeal remedies available under the Constitution and the laws of the United States for injunctive or declaratory relief.

Preemption and § 1983 are completely distinct and separate avenues of enforcing federal law. The remedies available under § 1983 are far more extensive than under preemption, including compensatory and punitive damages against state actors in their individual capacities, compensatory damages against municipalities, and attorneys' fees. *See City of Newport v. Fact Concerts, Inc.*, 453 U.S. 247 (1981); 42 U.S.C. § 1988. Preemption claims, in contrast, seek only to enforce the structural relationship between federal and state law by obtaining prospective equitable relief against state and local officials in their official capacities.

"Remedies designed to end a continuing violation of federal law are necessary to vindicate the federal interest in assuring the supremacy of that law." *Green v. Mansour*, 474 U.S. 64, 68 (1985). For a non-frivolous preemption claim, "denial of a judicial remedy would undermine federal supremacy and subvert the rule of law by enabling state officers to proceed with enforcement of an invalid state law, to the detriment of private parties." David Sloss, *Constitutional Remedies for Statutory Violations*, 89 Iowa L. Rev. 355, 409 (2004).

Several members of this Court have stressed that preemption claims and § 1983 serve different

purposes and have different requirements. In *Golden State Transit Corp. v. City of Los Angeles*, 493 U.S. 103 (1989), for example, Justice Kennedy explained that even though he would have held that the plaintiff could not bring its action under § 1983, nevertheless:

> we would not leave the [plaintiff] without a remedy. Despite what one might think from the increase of litigation under the statute in recent years, § 1983 *does not provide the exclusive relief* that the federal courts have to offer. * * * [P]laintiffs may vindicate [statutory] preemption claims by seeking declaratory and equitable relief in the federal district courts through their powers under federal jurisdictional statutes. See 28 U.S.C. § 1331 (1982 ed.); 28 U.S.C. § 2201; 28 U.S.C. § 2202 (1982 ed.). These statutes do not limit jurisdiction to those who can show the deprivation of a right, privilege, or immunity secured by federal law within the meaning of § 1983.

Id. at 119 (Kennedy, J., dissenting) (some citations omitted, emphasis added).

Petitioner asserted in its reply brief in *ILC II* that Justice Kennedy's *Golden State* dissent indicates that an "immunity" is needed for a preemption claim. Pet. Reply in *ILC II* at 6. In fact, Justice Kennedy said precisely the opposite: "Preemption concerns the federal structure of the Nation rather than the securing of rights, privileges, and immunities to individuals." 493 U.S. at 117. *See also Hagans v. Lavine*, 415 U.S. 528, 553 (1974) (Rehnquist, J., dissenting) (a claim that state

regulations conflict with federal regulations would properly invoke federal question jurisdiction to determine whether the state regulations are "invalid under the Supremacy Clause of the United States Constitution").

Indeed, petitioner, in contending on the basis of no supporting precedent, the novel view that the rules applicable to whether a person injured by preempted state action may obtain injunctive relief are those rules applicable to § 1983, ignores statements in *Golden State* in which the Court has specifically highlighted the differences between § 1983 and preemption:

> Given the *variety of situations* in which preemption claims may be asserted, in state court and in federal court, it would be obviously incorrect to assume that a federal right of action *pursuant to § 1983* exists every time a federal rule of law pre-empts a state regulatory authority.

Golden State Transit Corp., 493 U.S. at 107-108 (emphasis added).

II. CERTIORARI SHOULD BE DENIED ON THE SECOND QUESTION BECAUSE THE DECISION BELOW IS A CORRECT APPLICATION OF THE MEDICAID ACT AND THERE IS NO RELEVANT DIVISION IN THE LOWER COURTS

1. Petitioner asserts that the Ninth Circuit's opinion does not comport with the text of the Medicaid statute. Pet. 3-7, 30-33. This claim is without basis. The opinion in this matter is mindful of the textual provisions of Section 30A, concluding

the evidence showed that the state statute conflicted with federal statutory requirements.

The Medicaid statute, in Section 30A, requires states to utilize "methods and procedures...to assure that payments are consistent with efficiency, economy, quality of care, and are sufficient to enlist enough providers" so that beneficiaries have the same access to services as the general population.

The evidence demonstrated that the state Legislature which enacted the rate cut never considered the impact of the rate cut on the Section 30A factors of efficiency, economy, quality, and access to care. Because the Legislature did nothing to assure that payments were sufficient to provide access to services comparable to the general population, the state statute conflicted with federal law.

Petitioner mischaracterizes the Ninth Circuit's evidentiary holding as setting numerous "specific requirements" for a study to comply with Section 30A. Pet. 31-33. In fact, the Ninth Circuit's opinion does not set forth any specifications for procedures or studies that would comply with Section 30A. On the contrary, the Ninth Circuit merely evaluated the evidence proffered by the parties and concluded the setting of the pharmaceutical rates lacked any consideration of numerous Section 30A factors. Instead, the evidence demonstrated that the rates were set for purely budgetary reasons. Pet. App. 20.

Further, the Dec. 2007 Myers and Stauffer cost study filed by petitioner as proof of the Legislature's compliance with Section 30A explicitly stated that the study did not contain any information about

access to services and that the "evaluation" of fees should include consideration of access to services. Pet. App. 55-56. The study similarly noted that it did not address efficiency and that this should be considered in setting rates. *Id.* Thus, the Ninth Circuit properly held that the study does not show that the rate cut was enacted in accordance with Section 30A.

Petitioner suggests that the Ninth Circuit erred in holding that the Legislature, as distinguished from the Department, was required to comply with Section 30A. Pet. App. 31-32. This Court held in *Ahlborn* that when a state *Legislature* enacts a statute that conflicts with the federal Medicaid law, the state statute is "unenforceable." *Arkansas Dept. of Health & Human Services v. Ahlborn*, 547 U.S. 268, 292 (2006). It is well established that the enactments of state Legislatures may be preempted by federal law. *See, e.g., Rowe v. New Hampshire Motor Transp. Ass'n*, 552 U.S. 364 (2008); *Blum v. Bacon*, 457 U.S. 132, 138 (1982); *Hines v. Davidowitz*, 312 U.S. 52 (1941). The Ninth Circuit properly analyzed the text and legislative history of the state law and found it conflicted with the textual requirements of Section 30A.

2. All Circuits which have ruled on the subject have unanimously concluded that although budgetary considerations, - which are not listed in the text of Section 30A as a relevant factor at all - may be considered by the rate setter along with the relevant factors of efficiency, economy, quality of care, and equal access, nevertheless, rates based purely on budgetary considerations, or in which budgetary considerations are the conclusive factor,

violate Section 30A. *See, e.g., Rite Aid of Pennsylvania, Inc. v. Houstoun*, 171 F.3d 842 (3d Cir. 1999); *Minnesota HomeCare Ass'n, Inc. v. Gomez*, 108 F.3d 917, 917 (8th Cir. 1997).

This being so, the claim of the petitioner that the Ninth Circuit is out of step with other Circuits on the basic issue of whether a State may reduce Medicaid provider payments purely for budgetary reasons, is without merit. Cases from the Fifth and Seventh Circuit addressed only the "equal access" provision of Section 30A. Those courts described the plaintiffs' appeal as not raising a failure of the state to consider the factors of efficiency, economy and quality of care. *See Evergreen Presbyterian Ministries Inc. v. Hood*, 235 F.3d 908, 932 (5th Cir. 2000); *Methodist Hospitals, Inc. v. Sullivan*, 91 F.3d 1026, 1029 (7th Cir. 1996). Similarly, the First Circuit did not address these requirements in rejecting the enforceability of Section 30A under 42 U.S.C. § 1983. *See Long Term Care Pharmacy Alliance v. Ferguson*, 362 F.3d 50, 59-60 (1st Cir. 2004). There is no split among the Circuits on whether the requirements of Section 30A can be disregarded; therefore, no review is warranted in respect to the Second Question asserted by petitioner.

CONCLUSION

For the reasons set forth above, the petition for a writ of certiorari should be denied.

Respectfully submitted,

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No. 09-1158

In The
Supreme Court of the United States

DAVID MAXWELL-JOLLY, DIRECTOR OF THE DEPARTMENT OF HEALTH CARE SERVICES, STATE OF CALIFORNIA, ET AL., PETITIONERS,

v.

CALIFORNIA PHARMACISTS ASSOCIATION, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF OF RESPONDENTS CALIFORNIA PHARMACISTS ASSOCIATION, CALIFORNIA MEDICAL ASSOCIATION, CALIFORNIA DENTAL ASSOCIATION, CALIFORNIA HOSPITAL ASSOCIATION, CALIFORNIA ASSOCIATION FOR ADULT DAY SERVICES, MARIN APOTHECARY, INC., SOUTH SACRAMENTO PHARMACY, FARMACIA REMEDIOS, INC., ACACIA ADULT DAY SERVICES, SHARP MEMORIAL HOSPITAL, GROSSMONT HOSPITAL CORPORATION, SHARP CHULA VISTA MEDICAL CENTER, SHARP CORONADO HOSPITAL AND HEALTHCARE CENTER, FE GARCIA AND CHARLES GALLAGHER IN OPPOSITION

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QUESTIONS PRESENTED

1. Whether individuals injured by a state law may maintain an action in federal court to enjoin a state official from enforcing that law on the ground that it is preempted by a federal law.

2. Whether a state law reducing Medicaid reimbursement rates is preempted by 42 U.S.C. § 1396a(a)(30)(A).

PARTIES TO THE PROCEEDING

Petitioners identify (Pet. iii) all 15 of the plaintiffs named in the complaint in the district court action as the *California Pharmacists* respondents. It appears, however, that the California Pharmacists Association, California Medical Association, California Dental Association, Marin Apothecary, Inc. d/b/a Ross Valley Pharmacy, South Sacramento Pharmacy, and Farmacia Remedios, Inc. were not parties in either of the court of appeals' proceedings arising from that action for which review is sought, and thus would not be respondents under Rule 12.6.

To the extent that they are respondents, however, they have consented to the filing of this brief on their behalf. Thus, the following discussion is only for purposes of accuracy.

The reason those six named plaintiffs are likely not respondents is that not all of the plaintiffs were appellants or appellees in the court of appeals in the appeals from the grant and denial of preliminary injunctions.

Plaintiffs California Medical Association and California Dental Association did not seek any preliminary relief and thus could not have been appellants or appellees.

PARTIES TO THE PROCEEDING—Continued

Five of the named plaintiffs (California Hospital Association, Sharp Memorial Hospital, Grossmont Hospital Corporation, Sharp Chula Vista Medical Center, and Sharp Coronado Hospital and Healthcare Center) sought a preliminary injunction regarding rates for hospitals. Dt. Ct. Dkt. 16. The preliminary injunction was denied, and they filed a notice of appeal. Dt. Ct. Dkt. 41.

The other eight named plaintiffs sought a single preliminary injunction in the district court regarding rate cuts for pharmacies and adult day health care centers. Dt. Ct. Dkt. 13. The preliminary injunction was denied for pharmacies, Pet. App. 86a-87a, and no one appealed that denial. The preliminary injunction was granted as to adult day health care centers, Pet. App. 104a, and petitioners appealed that preliminary injunction. Although petitioners did not identify who the appellees were in that appeal, it seems that the only appropriate appellees would have been the four plaintiffs who benefitted from that order, *i.e.*, plaintiffs Acacia Adult Day Services, the California Association for Adult Day Services, and Fe Garcia (incorrectly listed on the captions as Fey Garcia) and Charles Gallagher (individuals who received services at adult day health care centers), and not those four plaintiffs who were interested only in the pharmacy cuts, *i.e.*, California Pharmacists Association, Marin Apothecary, Inc. d/b/a Ross Valley Pharmacy, South Sacramento Pharmacy, and Farmacia Remedios, Inc.

CORPORATE DISCLOSURE

The non-individual respondents that appear on the cover have no parent corporations and no publicly held company owns any stock in these respondents.

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INTRODUCTION

This is a tag-along petition filed by petitioners in an attempt to bolster their contention that the court of appeals' decision in *Independent Living Center of Southern California v. Shewry*, 543 F.3d 1050 (2008), cert. denied, 129 S. Ct. 2828 (2009), on further proceedings, 572 F.3d 644 (2009), petition for cert. pending, No. 09-958, is resulting in repeated judicial intervention in state Medicaid decisions both within the circuit and nationwide. It has no independent significance.

On March 24, 2010, the Court invited the Solicitor General to file a brief expressing the views of the United States in No. 09-958. No similar invitation is warranted in this case, and there is no need to hold this petition pending the filing of the federal government's brief. That is because the judgment in this case can be affirmed on bases unrelated to the procedural violations of Section 1396a(a)(30)(A), which is the basis of petitioners' challenge, or the enforcement of the Medicaid Act's preemptive effect through the Supremacy Clause.

STATEMENT

A. Statutory Framework

1. Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.* (the "Medicaid Act"), is a cooperative federal-state program that provides federal financial assistance to participating States to enable them to provide medical treatment for the poor, elderly, and disabled. A State's participation in Medicaid is

voluntary. To receive federal funds, however, States are required to establish and administer their Medicaid programs through individual "State plans for medical assistance" approved by the federal Secretary of Health and Human Services (HHS). 42 U.S.C. § 1396. In response to the current economic crisis, the federal government currently pays California approximately $3.10 for every $2 the State spends through its plan. 75 Fed. Reg. 5,325, 5,326 (Feb. 2, 2010).

When a State desires to change its existing plan, it must submit a plan amendment to HHS. HHS has 90 days to make a determination whether the amendment complies with the Medicaid Act. 42 U.S.C. § 1396n(f)(2). If HHS does not act within this time frame, the state plan amendment is considered approved. *Ibid.* If, however, HHS asks for more information from the State, HHS has a second 90-day time frame within which to approve or disapprove the amendment, beginning on the date the requested information is received from the State. *Ibid.* A State is not permitted to implement a plan change until it receives federal approval. *Exeter Mem. Hosp. Ass'n v. Belshe*, 145 F.3d 1106 (9th Cir. 1998); 42 C.F.R. § 430.20(b)(2) (incorporating Section 447.256(a)(2), which incorporates Section 447.253(i), which provides that the state "Medicaid agency must pay for * * * services using rates determined in accordance with methods and standards specified in an approved State plan").

The Medicaid Act provides specific requirements for state plans and reimbursement rates. Section 1396a(a)(30)(A), the provision at issue in this case, provides that a state plan

> must * * * provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan * * * as may be necessary [1] to safeguard against unnecessary utilization of such care and services and [2] to assure that payments are consistent with efficiency, economy, and quality of care and [3] are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

42 U.S.C. § 1396a(a)(30)(A) (bracketed numbers added).

This case involves the requirements of Section 1396a(a)(30)(A) that mandate that a state plan establish payment rates for medical care and services available under the plan that are both consistent with quality medical care (the "quality of care" provision) and sufficient to enlist enough providers to ensure that medical care and services are as available to recipients as is generally available to the public in the same geographical area (the "equal access" or "enough providers" provision).

2. The Legislature enacted Assembly Bill 1183 ("AB 1183"), on September 30, 2008. Pet. App.

198a-217a. Section 45 of AB 1183 added a new Section 14105.191 that, effective March 1, 2009, required a five percent rate cut for certain Medi-Cal fee-for-service payments and benefits, including adult day health care centers (ADHCs) and certain hospital services, and a one percent rate reduction for all other fee-for-service benefits (including hospital outpatient services). Pet. App. 205a-210a.

Contrary to petitioners' claim (Pet. 9, 36), nothing in AB 1183 gave petitioners discretion in determining whether or not to implement the rate cuts adopted by the statute. To the contrary, AB 1183 provides that "the director *shall* reduce provider payments, as specified in this section" "[n]otwithstanding any other provision of law." Pet. App. 205a.[1]

B. Factual Background

1. Respondents are comprised of three sets of plaintiffs who brought three separate actions. The respondents filing this brief are various Medi-Cal providers (including hospitals and ADHCs), associations representing those providers, and two individuals who receive Medi-Cal services.

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[1] Both the district court and court of appeals held that petitioners retained no discretion under state law to decline to implement the rate cuts even if they violated federal requirements. Pet. App. 23a-28a, 97a. Petitioners have not sought to show that the lower courts' reading of the statute is "'plain' error," *Brockett v. Spokane Arcades, Inc.*, 472 U.S. 491, 500 n.9 (1985), as they would be required to do to overturn that reading of the state statute.

Petitioners are various California officials in their official capacities. Petitioner Maxwell-Jolly, the Director of the California Department of Health Care Services, was sued by all respondents in all three actions. Additional state officials were sued by only one set of plaintiffs in one of the other actions. Yet, for ease of reference, this opposition refers to petitioners in the plural even when discussing solely the action brought by these respondents.

On January 29, 2009, respondents sued petitioners, to prevent the implementation of AB 1183. Respondents alleged, inter alia, that the actions of petitioners to implement the five-percent and one-percent payment reductions of AB 1183 were pre-empted under the Supremacy Clause by Section 1396a(a)(30)(A).

a. The district court granted respondents' motion for a preliminary injunction as applied to ADHCs. Pet. App. 84a-105a. ADHCs provide an alternative to institutional care, responding to the State's need "to establish and to continue a community-based system of quality adult day health care which will enable elderly persons or adults with disabilities to maintain maximum independence." Cal. Health & Safety Code § 1570.2.

The district court found that, over ten years earlier, the court of appeals' decision in *Orthopaedic Hospital v. Belshe*, 103 F.3d 1491 (9th Cir. 1997), cert. denied, 522 U.S. 1044 (1998), had established that Section 1396a(a)(30)(A) required that "when the State

of California seeks to modify reimbursement rates for health care services provided under Medi-Cal program, it must consider efficiency, economy, and quality of care, as well as the effect of providers' costs on those relevant statutory factors." Pet. App. 95a.

The district court found that respondents had established a "strong likelihood of success on the merits" because it "appears that the Legislature * * * did not properly consider relevant factors prior to the passage of the five percent rate reduction in AB 1183." Pet. App. 99a. In particular, the district court found that while there was evidence that the Legislature discussed and modified the rate reductions in various respects, "none of this demonstrates that the Legislature relied on responsible cost studies providing reliable data in setting the rates." Pet. App. 98a-99a.

The district court also rejected petitioners' claim that their performance of a post-enactment analysis met the requirements of Section 1396a(a)(30)(A). First, the district court determined that petitioners did not have "any discretion to determine whether the five percent rate reduction should be implemented based on the Department's consideration of the relevant factors." Pet. App. 97a. Because the Department had "no authority to alter the rate reduction," it was not the "body responsible for rate setting" that was required to "consider the relevant factors." Pet. App. 98a. Moreover, the district court was "not persuaded that the analysis actually conducted by the Department was adequate" because it relied on an

inadequate proxy to measure ADHC costs. Pet. App. 99a.

The district court also found respondents had established irreparable injury to Medi-Cal beneficiaries due to the proposed rate cuts because they would be "at risk of losing access to ADHC services." Pet. App. 102a. That, in turn, created a "significant threat to the health of Medi-Cal recipients." Pet. App. 103a.

The balance of hardships and public interest also weighed in favor of a preliminary injunction, the district court found, because the proposed cuts might not save the State any money because "many Medi-Cal beneficiaries may turn to more costly forms of medical care, such as emergency room care." Pet. App. 103a n.7. In addition, the court noted, its injunction did not prevent the State from deciding "to implement a rate change upon making a properly reasoned and supported analysis." Pet. App. 104a.

No motion to stay the injunction was filed.

b. In a separate order, the district court denied respondents' motion for a preliminary injunction as applied to hospitals. Pet. App. 106a-127a. As with the ADHCs, the district court found that respondents had established a strong likelihood of success on the merits because the Legislature did not consider any of the relevant factors before it enacted AB 1183. Pet. App. 119a-120a. For this reason, it did not reach respondents' alternative argument that AB 1183 was preempted because it was implemented

without approval from the federal government. Pet. App. 120a n.9.

The district court found, however, that respondents did not establish that Medi-Cal beneficiaries "will go without access to needed inpatient and outpatient services under the AB 1183 rate reductions." Pet. App. 126a.

2. Petitioners appealed the grant of the preliminary injunction regarding ADHCs and respondents appealed the denial of the preliminary injunction regarding hospitals.

a. Without objection from petitioners, the appeals were assigned to a panel that previously had addressed preliminary injunction appeals involving Medi-Cal.

While briefing was on-going, petitioners sought to vacate the panel's opinion in *Independent Living Center of Southern California, Inc. v. Maxwell-Jolly*, 572 F.3d 644 (9th Cir. 2009), petition for cert. pending, No. 09-958, on the ground that the appeal and cross-appeal in that case were moot when the panel issued its opinion. The panel denied that motion, finding that the appeals were not moot. *See* 590 F.3d 725 (9th Cir. 2009). In doing so, the panel found that the Attorney General had engaged in "a clear violation of Rule 5-200" of the California Rules of Professional Conduct, which prohibits members of the bar from misleading the judiciary through any false statement, and noted that the Attorney General's conduct gave the panel "pause about accepting the

veracity of future pleadings filed by the Attorney General on behalf of the Director, if not more generally." *Id.* at 730.

Petitioners then moved to recuse the judges of that panel from sitting on this appeal. The panel denied the motion on January 15, 2010. It explained that the Attorney General had "misled the court" in the prior case and "having been less than truthful once before, the Attorney General is in no position to question this panel's impartiality for simply calling him to account for his lack of candor." 09-55532 C.A. Order at 5-6 (Jan. 15, 2010). The panel concluded that the Attorney General "may rest assured that he will receive fair and unbiased treatment from the court, as will all other litigators who are willing to comply with the rules that govern their professional conduct as well as the applicable rules of court." *Id.* at 6.

b. The court of appeals affirmed the district court's entry of a preliminary injunction regarding the rate cut as applied to ADHCs. Pet. App. 1a-36a.

The court of appeals confirmed that "if the legislature elects to by-pass the Department and set the rates itself, it must engage in the same principled analysis [the court of appeals] required of the Director in" *Orthopaedic Hospital v. Belshe*, 103 F.3d 1491 (9th Cir. 1997), cert. denied, 522 U.S. 1044 (1998). Pet. App. 13a-14a. It expressly noted that it was "not telling the State something new," and that its holding was apparent in earlier decisions. Pet. App. 15a. It

also was "consistent with that of [other] circuits, where in the context of legislative, as opposed to agency, rate-setting, they too have focused on ensuring that the legislative body had information before it so that it could properly consider efficiency, economy, quality of care, and access to services *before* enacting rates." Pet. App. 15a-16a.

The court of appeals "emphasize[d] that the State need not follow 'any prescribed method of analyzing and considering the [Section 1396a(a)(30)(A)] factors," but that Congress intended that the decisionmaker engage in some "study [of] the impact of the contemplated rate change on the statutory factors *prior to* setting rates." Pet. App. 17a. The court of appeals further held that the district court did not commit clear error in finding that the legislature did not adequately consider the Section 1396a(a)(30)(A) factors before enacting AB 1183, Pet. App. 17a-21a, but was concerned "solely with budgetary matters," Pet. App. 20a, which contravened *Orthopaedic's* holding that "purely budgetary concerns" were not a sufficient ground for setting rates. 103 F.3d at 1498-1499 & n.3.

In addition, the court of appeals held that, as a matter of state law, petitioners did not have discretion not to implement the legislatively-set rates and thus any post-enactment study was not the meaningful consideration required by Section 1396a(a)(30)(A). Pet. App. 23a-28a nn.3-5. In the alternative, it held that even if petitioners did have that authority, the district court did not clearly err in holding that

petitioners' analysis was inadequate because it looked to the average costs of only six nursing facilities, with widely varying costs, as a proxy for the 313 ADHCs in the Medi-Cal program. Pet. App. 29a. Respondents provided evidence showing that there was no basis for equating the costs of these six facilities with ADHCs, which provide a completely different range of services. Pet. App. 100a n.6. Petitioners were forced to rely on this inadequate proxy because, despite a statute enacted in 2006 that required it to establish a cost-based system by 2010, Cal. Welf. & Inst. Code § 14571.2(f), it had just begun the process of auditing ADHC costs, Pet. App. 29a.

As another alternative for sustaining the district court's preliminary injunction, the court of appeals held that if compliance with Section 1396a(a)(30)(A) was judged solely based on substantive compliance with the "enough providers" provision, it "would find that violation here" because petitioners "concede[] that here, the evidence indicates that at least some ADHC Medi-Cal providers would stop treating beneficiaries due to AB 1183." Pet. App. 33a.

The court of appeals also held that the district court did not clearly err in finding irreparable injury nor abuse its discretion in determining the balance of equities or the public interest. Pet. App. 34a-35a.

c. The court of appeals reversed the district court's denial of a preliminary injunction regarding the rate cut as applied to hospitals. Pet. App. 37a-41a. The court of appeals agreed with the district court's

determination of respondents' likelihood of success on the merits for all the reasons the appellate court articulated for ADHCs. Pet. App. 40a. The court of appeals determined, however, that the district court had abused its discretion in finding a lack of irreparable injury. Respondents had shown that they were being reimbursed less than the amount to which they otherwise were entitled and that they would not be able to recover those payments from petitioners in light of the State's Eleventh Amendment immunity. Pet. App. 38a-40a.[2]

3. Petitioners did not move to stay the mandates, both of which issued on March 25, 2010.

On remand, the district court denied petitioners' oral motion to stay the action. Dt. Ct. Dkt. 83 at 1. The parties agreed to engage in discovery and then file dispositive motions on a permanent injunction on or before February 28, 2011. Dt. Ct. Dkt. 80 at 3. The parties represented that they "anticipate that the matter will be resolved by dispositive motions." *Ibid.*

REASONS THE PETITION SHOULD BE DENIED

As with petitioners' other pending petition for certiorari in No. 09-958, the questions raised by petitioners from these preliminary injunction cases do

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[2] The court of appeals had earlier granted a stay of the rate cut pending appeal. Pet. App. 42a-51a. The court of appeals denied petitioner's petition for rehearing en banc without recorded dissent. Pet. App. 52a.

not warrant this Court's review and, even if they did, these cases are not appropriate vehicles to address them.

Petitioners assert (Pet. 28) that the decisions of the court below involve an issue of national importance. But California has been alone in demonstrating a plain disregard for the rate-setting requirements embodied in the Medicaid Act. Instead of engaging in a reasoned analysis before enacting cuts in its payments to providers of medical and other essential services to Medicaid recipients, California sought to cut payments by arbitrary amounts without regard to the likely impact of those cuts and irrespective of costs. No court in the 45-year history of the Medicaid Act program has interpreted the Act to allow wholly budget-driven reductions to Medicaid rates without consideration of the effect of the reductions on "efficiency, economy, and quality of care," or whether the reduced rates were sufficient "to enlist enough providers so that care and services are available" to eligible individuals. 42 U.S.C. § 1396a(a)(30)(A). Consequently, the vast majority of cases where injunctions have been granted relating to Medicaid reimbursement have been in California.

This focus on California also reflects the fact that, even before its current attempts to cut rates, California's payments per enrollee were the nation's lowest for adults, and second lowest in the nation for all enrollees. The Kaiser Family Foundation, *Medicaid Payments per Enrollee, FY2006, available at* http://www.statehealthfacts.org/comparetable.jsp?ind=

183&cat=4 (last visited May 20, 2010). California's payments per enrollee in 2006 were less than 60% of the national average. *Ibid.*

Petitioners have identified only three injunctions entered in the past 21 months against States other than California—those cases involved two temporary restraining orders followed by mootness or settlement and one stipulated permanent injunction. Pet. App. 237a-242a. And, although petitioners do not trumpet the fact, the court of appeals below also has rejected efforts to obtain injunctive relief in cases raising similar claims when the facts did not establish a need for immediate intervention. *See National Ass'n of Chain Drug Stores v. Schwarzenegger*, No. 09-57051, 2010 WL 1506928 (9th Cir. Apr. 15, 2010) (affirming denial of preliminary injunction); *Carter v. Gregoire*, No. 09-35755, 2010 WL 235264 (9th Cir. Jan. 20, 2010) (same). This is hardly evidence of judicial overreaching.

Thus, while petitioners are correct that lawsuits have been filed seeking relief under the Supremacy Clause (although it is unclear whether such suits are being filed at any greater rate than in previous years), the results of those suits demonstrate that States that follow the mandates of federal Medicaid law will not suffer budgetary "catastrophes" as a result of the preemption holding of the court below. Instead, the courts are playing their traditional role as a last line of defense against arbitrary and unreasoned state conduct that conflicts with federal law.

I. THESE CASES ARE NOT APPROPRIATE VEHICLES TO ADDRESS PETITIONERS' CLAIMS

A. Review Of The First Question Presented Is Unwarranted Because The Court's Resolution Would Not Affect The Authority Of The District Court To Entertain Respondents' Preemption Claim

This case is not an appropriate vehicle to resolve the first question presented by petitioners—namely, whether individuals injured by a state law may maintain an action in federal court to enjoin a state official from enforcing that law on the ground that it is preempted by a federal law—because the Court's resolution of that question would not affect the authority of courts to entertain respondents' claims. In California, a well-established state cause of action provides respondents a method for raising the same preemption claim. This Court has denied review in comparable circumstances where the resolution of the question presented "could not change the result reached below, since petitioner[s] would be liable under either federal or state law." Eugene Gressman, *et al.*, *Supreme Court Practice* 248 (9th ed. 2007).

California law provides a cause of action in which a party injured by a state official's failure to comply with federal law may sue for a writ of mandamus to compel that state official to act. Well before the court of appeals' decisions below, the state courts made clear that this state cause of action does not require

the showing that the federal statute secures a "right," as that term has developed its meaning under 42 U.S.C. § 1983, but only a showing that the plaintiff is "beneficially interested" in compliance with the federal law. *California Homeless & Housing Coalition v. Anderson*, 31 Cal.App.4th 450, 458 (1995); *Doctor's Med. Lab., Inc. v. Connell*, 69 Cal.App.4th 891, 896 (1999); *California Ass'n for Health Servs. at Home v. Department of Health Servs.*, 148 Cal.App.4th 696, 706 (2007); *Mission Hosp. Reg'l Med. Ctr. v. Shewry*, 168 Cal.App.4th 460 (2008), rev. denied (Cal. 2009). Indeed, that state cause of action has been used to enforce the very statutory provision—Section 1396a(a)(30)(A)—that respondents have demonstrated petitioners violated in these cases. *See, e.g., California Ass'n of Health Facilities v. Department of Health Servs.*, No. A107551, 2006 WL 3775842 (Cal. Ct. App. Dec. 26, 2006).

Although this state cause of action was not the basis for the interlocutory rulings of the court below, this Court does not generally grant review unless a reversal would change the position of the parties in some concrete fashion. *See The Monrosa v. Carbon Black Export, Inc.*, 359 U.S. 180, 183 (1959). Here, even if petitioners were to prevail on their first question presented, respondents could still pursue their claims through the state action, arguably in federal court because the claims would arise under federal law. *See* Pet. Mem. in Opp. to Mot. to Remand at 5-6, 8-9, *California Medical Ass'n v. Shewry*, No. 08-03363 (C.D. Cal. June 9, 2008) (argument by petitioners

that state mandamus action to enforce federal Medicaid Act arises under federal law pursuant to *Grable & Sons Metal Prods., Inc. v. Darue Eng'g & Mfg.*, 545 U.S. 308 (2005)); Pet. Mem. in Opp. to Mot. for Remand at 3-6, *California Health Ass'n v. Shewry*, No. 06-4027 (N.D. Cal. Aug. 14, 2006) (same).

B. Review Of The Second Question Presented Is Unwarranted Because The State Has Stalled The Federal Approval Process

As with the case at issue in No. 09-958, there is also a lurking contingency that makes this case a poor vehicle for this Court's review and, in this case, provides an alternative basis for affirmance even apart from Section 1396a(a)(30)(A).

As noted above, a State may not implement rate cuts until HHS approves an amendment to the state plan. *See* page 2, *supra*. Petitioners' proposed state plan amendment reflecting AB 1183's changes has not been approved by HHS. That failure of petitioners to get approval was one of the grounds pressed by respondents for obtaining the injunction in both the district court and the court of appeals, although it was not reached by either court. Pet. App. 120a n.9; 09-55365 Resp. C.A. Br. 39.

Instead of obtaining approval, petitioners have stalled the entire approval process. On September 30, 2008, petitioners submitted their state plan

amendment to HHS. Pet. 9.[3] Petitioners explained to HHS that the state plan amendment it submitted for approval would "provide authority for the * * * payment reductions to specified providers and programs."

In December 2008, HHS responded with a nine-page request for additional information. App., *infra*, 1a-20a. With regard to compliance with Section 1396a(a)(30)(A), HHS explained that the state plan amendment that was submitted "is inadequate and does not provide sufficient information to understand the reimbursement methodology." App., *infra*, 8a. HHS asked petitioners to explain "[w]hat impact, if any, does this proposed [state plan amendment] have on access to providers providing these non-institutional services in California?" App., *infra*, 9a.

That HHS letter concluded by explaining that the request for additional information "has the effect of stopping the 90-day clock with respect to [HHS] taking further action on this State plan submittal" and stating that a "new 90-day clock will not begin until we receive your response to this request for additional information." App., *infra*, 20a. Finally, the letter stated that "[i]n accordance with our guidelines to all State Medicaid Directors dated January [2], 2001, we request that you provide a formal response

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[3] As petitioners explain (Pet. 9 n.3), that state plan amendment was subsequently split into a number of separate plan amendments. The language quoted in the text, and the language drawn from HHS' response, was virtually identical for all of the state plan amendments.

to this request for additional information within ninety (90) days of receipt." *Ibid.*

It has now been 18 months since HHS sent that letter and respondents are informed by HHS that, as of March 30, 2010, petitioners still have not provided a formal response. App., *infra*, 24a. That alone is sufficient grounds for HHS to disapprove the proposed amendment.[4] Although petitioners claim (Pet. 37) that they have submitted some materials requested by HHS and are in "constant communication" with the agency, the fact is that the clock has stopped on HHS' processing of the amendment and, until the clock is restarted and the amendment is approved, the cuts should not take effect.

Indeed, according to a document from HHS, California currently is in default on multiple requests for additional information. App., *infra*, 23a-24a. This puts California's complaint that private litigation has usurped the role of HHS in a particularly poor light, given that California does not seem to want to be accountable to HHS (or anyone else) as to its compliance with the Medicaid Act, despite continuing to take billions of dollars in federal funds.

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[4] *See* Letter from Timothy Westmoreland, Director, Health Care Finance Administration, U.S. Dep't of Health & Human Servs., to State Medicaid Directors, at 1 (Jan. 2, 2001), *available at* http://www.cms.hhs.gov/smdl/downloads/smd010201.pdf (last visited May 20, 2010).

II. CERTIORARI SHOULD BE DENIED ON THE FIRST QUESTION FOR THE ADDITIONAL REASON THAT THERE IS NO DIVISION IN THE LOWER COURTS AND THE DECISIONS BELOW ARE A CORRECT APPLICATION OF THIS COURT'S SETTLED SUPREMACY CLAUSE JURISPRUDENCE

Every court of appeals is in accord with the holding of the court below that a federal court may resolve, on the merits, an action against a state official for injunctive relief alleging that a state law is preempted by a federal law.

Petitioners now avoid complaining of any conflict in the courts of appeals, but instead contend (Pet. 27 & n.10) that the fact that courts of appeals across the country all have reached the *same* result as the court below is a ground for this Court's review.[5] But that

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[5] In addition to the cases from the First, Fifth, Eighth, and D.C. Circuits cited by petitioners, decisions from the Second, Third, Fourth, Sixth, and Seventh Circuits likewise are in accord. *See Western Air Lines, Inc. v. Port Auth. of N.Y. & N.J.*, 817 F.2d 222, 225-226 (2d Cir. 1987), cert. denied, 485 U.S. 1006 (1988); *St. Thomas-St. John Hotel & Tourism Ass'n v. Virgin Islands*, 218 F.3d 232, 241 (3d Cir. 2000); *Verizon Maryland, Inc. v. Global NAPS, Inc.*, 377 F.3d 355, 368-369 (4th Cir. 2004); *GTE North, Inc. v. Strand*, 209 F.3d 909, 916 (6th Cir.), cert. denied, 531 U.S. 957 (2000); *Illinois Ass'n of Mortgage Brokers v. Office of Banks & Real Estate*, 308 F.3d 762, 765 (7th Cir. 2002). Although petitioners have in the past questioned the governing rule in the Eleventh Circuit, the en banc decision in *BellSouth Telecommunications, Inc. v. MCImetro Access Transmission Services, Inc.*, 317 F.3d 1270 (11th Cir. 2003) (en banc), reached

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overwhelming consensus in the courts of appeals is due to this Court's consistent sanctioning of such actions.[6]

Petitioners try to distinguish the decisions below from all the others on the ground that, they claim (Pet. 37-38), Congress purposefully amended the Medicaid Act to make Section 1396a(a)(30)(A) unenforceable by private parties. But that argument makes the decisions below even less worthy of review, as there is no split with any other court of appeals as to

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beyond any jurisdictional ruling and held that, apart from any express cause of action available under the relevant statute, "[f]ederal courts must resolve" on the merits "the question of whether a public service commission's order violates federal law." *Id.* at 1278 (citing *Verizon Maryland Inc. v. Public Serv. Comm'n*, 535 U.S. 635 (2002)).

[6] *See* Richard H. Fallon, Jr., Daniel J. Meltzer & David L. Shapiro, *Hart & Wechsler's The Federal Courts & The Federal System* 903 (5th ed. 2003); 13D Charles A. Wright, Arthur R. Miller & Edward H. Cooper, *Federal Practice and Procedure* § 3566 (3d ed. 2008); *Golden State Transit Corp. v. City of Los Angeles*, 493 U.S. 103, 119 (1989) (Kennedy, J., dissenting). Accepting petitioners' contrary view would call into question the propriety of many preemption cases brought against state officials in federal court, including a number that have been heard by this Court on the merits in the past few Terms, *see, e.g.*, *Cuomo v. Clearing House Ass'n, L.L.C.*, 129 S. Ct. 2710 (2009); *Chamber of Commerce of the United States v. Brown*, 128 S. Ct. 2408 (2008); *Rowe v. New Hampshire Motor Transport Ass'n*, 552 U.S. 364 (2008); *Watters v. Wachovia Bank, N.A.*, 550 U.S. 1 (2007), including cases involving preemption under the Medicaid Act, *see Arkansas Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S. 268 (2006); *PhRMA v. Walsh*, 538 U.S. 644 (2003).

whether any portions of Section 1396a(a) may be enforced through the Supremacy Clause.

In any event, petitioners are wrong. As evidence of congressional intent, petitioners rely solely on the legislative history surrounding the 1997 repeal of a separate provision of the Medicaid Act, known as the Boren Amendment, previously codified at 42 U.S.C. § 1396a(a)(13)(A). Seven years before the Boren Amendment's repeal, this Court held that it was enforceable through 42 U.S.C. § 1983. *See Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498 (1990). But, when Congress apparently grew dissatisfied with that result, it did not eliminate the Section 1983 cause of action while preserving the Boren Amendment's substantive requirements. Instead, Congress simply repealed those specific substantive requirements that it no longer wished to be enforced. *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4711(a), 111 Stat. 251, 507.

At the time of the Boren Amendment's repeal, however, Section 1396a(a)(30)(A) had consistently been held to impose an independent, enforceable requirement in establishing reimbursement standards for provider services. *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491 (9th Cir. 1997), cert. denied, 522 U.S. 1044 (1998); *Visiting Nurse Ass'n of North Shore, Inc. v. Bullen*, 93 F.3d 997, 1004 (1st Cir. 1996), cert. denied, 519 U.S. 1114 (1997); *Methodist Hospitals, Inc. v. Sullivan*, 91 F.3d 1026, 1029 (7th

Cir. 1996); *Arkansas Med. Soc., Inc. v. Reynolds*, 6 F.3d 519 (8th Cir. 1993).[7] The Boren Amendment's "repeal, like its enactment, modified § 13(A) alone; it effected no change to § 30(A)." *Alaska Dep't of Health & Soc. Servs. v. Centers for Medicare & Medicaid Servs.*, 424 F.3d 931, 940-941 (9th Cir. 2005). Thus, petitioners' reliance on a snippet from a 1997 committee report discussing the repeal of the Boren Amendment that described the repeal as precluding enforcement by providers of "any other" provision of Section 1396a, H.R. Rep. No. 105-149, at 591 (1997), does not alter the fact that the text of Section 1396a(a)(30)(A) was not amended in 1997. That subsequent legislative history is thus irrelevant. *See Doe v. Chao*, 540 U.S. 614, 626-627 (2004).

III. CERTIORARI SHOULD BE DENIED ON THE SECOND QUESTION FOR THE ADDITIONAL REASON THAT THERE IS NO RELEVANT DIVISION IN THE LOWER COURTS AND THE DECISIONS BELOW ARE A CORRECT APPLICATION OF THE MEDICAID ACT

Petitioners claim (Pet. 34) that the Ninth Circuit's interpretation of Section 1396a(a)(30)(A) makes

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[7] *See also Clark v. Kizer*, 758 F. Supp. 572, 578 (E.D. Cal. 1990), aff'd in relevant part, 967 F.2d 585 (9th Cir. 1992); *Illinois Hosp. Ass'n v. Ill. Dep't of Pub. Aid*, 576 F. Supp. 360, 368 (N.D.Ill.1983); *Daniel B. DeGregorio v. O'Bannon*, 500 F. Supp. 541 (E.D. Pa. 1980); *Opelika Nursing Home, Inc. v. Richardson*, 356 F. Supp. 1338, 1343 (M.D. Ala. 1973).

it an "outlier." But the court of appeals correctly held that the district court did not abuse its discretion in finding that respondents had established a likelihood of success on the merits of their claims sufficient to sustain a preliminary injunction.

The court of appeals "emphasize[d] that the State need not follow 'any prescribed method of analyzing and considering the [Section 1396a(a)(30)(A)] factors." Pet. App. 17a. And the court of appeals repeatedly has explained that under any interpretation (including that of other circuits or even that of petitioners themselves) California's across-the-board rate reductions—which were made solely for budgetary reasons; without any prior consideration of efficiency, economy, and quality of care; and which would create access and quality of care problems for beneficiaries—do not comply with the statute.

A. The Outcome Would Be The Same Under Petitioners' Proposed Interpretation Of The Statute

Because the court of appeals also held that petitioners did not satisfy Section 1396a(a)(30)(A)'s substantive requirements, the outcome in these cases would not change even if, as petitioners contend, the court erred in interpreting the provision as containing a procedural component.

Petitioners acknowledge that Section 1396a(a)(30)(A) contains substantive requirements, contending only that the provision "does not preclude a state from reducing rates to address a budgetary crisis, *so long*

as the substantive requirements of the statute are met." Pet. 31 (emphasis added). Indeed, petitioners have previously argued to this Court that Section 1396a(a)(30)(A) "sets some substantive objecti[ves]," including that the rates cannot be so low "as to create an access or quality of care problem for beneficiaries." 09-958 Pet. 33, 26.[8]

The court of appeals squarely held in the decision below that even if compliance with Section 1396a(a)(30)(A) was judged solely based on substantive requirements, it "would find that violation here." Pet. App. 33a. Similar findings were affirmed in the other appellate cases that petitioners combined in this petition, albeit sometimes phrased in terms of irreparable injury. Pet. App. 40a, 57a, 81a-82a.

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[8] The history of Section 1396a(a)(30)(A) confirms petitioners' acknowledgement that the provision's requirement that rates be "sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area" is a substantive obligation. In the public law that added this language, Congress entitled this amendment: "Codification of adequate payment level provisions." Pub. L. No. 101-239, § 6402(a), 103 Stat. 2106, 2260 (1989). The legislative history confirms that this requirement (which previously existed as an agency regulation) was added to Section 1396a(a)(30)(A) because Congress was concerned that States were setting rates too low to attract providers. "[W]ithout adequate payment levels, it is simply unrealistic to expect physicians to participate in the program." H.R. Rep. No. 101-247, at 389-390 (1989).

Petitioners do not challenge this finding. Accordingly, review of the court of appeals' alternative holdings is not warranted, as it would not affect the merits judgment below.

B. The Court Of Appeals Has Provided Clear Notice To Petitioners Of Its Consistent Textually-Rooted Interpretation Of Section 1396a(a)(30)(A) And Petitioners Retain The Option Of Submitting Additional Evidence At The Permanent Injunction Stage

1. Claiming that the court of appeals continually moves the goal posts, petitioners argue that the decisions below add new, unanticipated wrinkles to complying with Section 1396a(a)(30)(A). That is incorrect. The court of appeals' interpretation of Section 1396a(a)(30)(A) has remained constant, and consistent with its text, since the court decided *Orthopaedic* over 13 years ago. The *Dominguez* respondents in their brief in opposition document all the errors in the petitioners' description of the court of appeals' holding. This opposition briefly focuses on the broader picture.

The decision in *Orthopaedic* made clear that the State had an obligation to perform its analysis of the Section 1396a(a)(30)(A) factors *before* the enactment of rate reductions. In that case, the state agency had implemented an increase in rates for certain services, but the plaintiffs argued that the agency had not considered the factors required by Section 1396a(a)(30)(A) and, by failing to do so, had provided

too little in terms of increases. The court of appeals agreed. It specifically rejected the agency's reliance on a study performed after it had set the rates. The court held that because the agency "did not consider hospitals' costs *when* reevaluating its rates, it has not appropriately applied § 1396a(a)(30)(A)." 103 F.3d at 1500 (emphasis added).

Likewise, *Orthopaedic* was clear that the entity that set the rates was the one that had to consider the relevant factors, because one "cannot know that it is setting rates that are consistent with efficiency, economy, quality of care and access without considering the costs of providing such services." *Id.* at 1496. Although the appeal in that case did not involve legislatively-set rates, such rates were challenged in the district court in that case, and the district court made clear that such rates would comply with Section 1396a(a)(30)(A) only if "the legislature in enacting the statute had expressly considered 'efficiency, economy, and quality of care.'" *Orthopaedic Hosp. v. Kizer*, No. 90-4209, 1992 WL 345652, at *9 (C.D. Cal. Oct. 5, 1992). Thus, as the court of appeals here correctly observed, it was "not telling the State something new" in these decisions. Pet. App. 15a.

2. Finally, petitioners disregard the fact that the decisions below addressed interlocutory orders regarding preliminary injunctions, and that petitioners are free to raise their claims of error with the district court after full discovery and briefing. So to the extent they believe the courts below overlooked or

misunderstood the facts, petitioners will have another chance to make their case.

If petitioners succeed in the district court in defeating entry of permanent injunctions, then petitioners will have prevailed without regard to the decisions in these interlocutory opinions. That is precisely the position petitioners currently are taking in the district court against the respondents filing this opposition, where the petitioners intend to take discovery and file for summary judgment. Dt. Ct. Dkt. 80 at 3. It is because "many orders made in the progress of a suit become quite unimportant by reason of the final result, or of intervening matters," *American Constr. Co. v. Jacksonville, T. & K. W. Ry. Co.*, 148 U.S. 372, 384 (1893), that this Court has held that the interlocutory posture of a decision "alone furnishe[s] sufficient ground" for denying review. *Hamilton-Brown Shoe Co. v. Wolf Bros. & Co.*, 240 U.S. 251, 258 (1916). That is true here.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted,

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No. 09-1158

IN THE

Supreme Court of the United States

DAVID MAXWELL-JOLLY,
Director of the Department of Health Care Services,
State of California, et al.,
Petitioners,

v.

CALIFORNIA PHARMACISTS ASSOCIATION, et al.,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF OF RESPONDENTS IN OPPOSITION

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QUESTIONS PRESENTED

1. Whether Medicaid recipients and providers who face imminent injury from a state statute that reduces Medicaid reimbursement rates may maintain a cause of action for injunctive relief under the Supremacy Clause on the ground that 42 U.S.C. § 1396a(a)(30)(A) preempts the state statute.

2. Whether a statute that reduces Medicaid reimbursement rates, for purely budgetary reasons and without any consideration of the effect of the reduction upon access to or the quality of Medicaid services, is preempted by the requirement of 42 U.S.C. § 1396a(a)(30)(A) that state Medicaid plans must "provide such methods and procedures relating to . . . the payment for . . . care and services available under the plan . . . as may be necessary . . . to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area."

LIST OF PARTIES

Petitioners are David Maxwell-Jolly, Director of the California Department of Health Care Services; John A. Wagner, Director of the California Department of Social Services; and Arnold Schwarzenegger, Governor of the State of California.*

Respondents in this Opposition Brief are Lydia Dominguez; Patsy Miller; Alex Brown, by and through his mother and next friend Lisa Brown; Donna Brown; Chloe Lipton, by and through her conservator and next friend Julie Weissman-Steinbaugh; Herbert M. Meyer; Leslie Gordon; Charlene Ayers; Willie Beatrice-Sheppard; Andy Martinez; Service Employees International Union United Healthcare Workers West; Service Employees International Union United Long-Term Care Workers; Service Employees International Union Local 521; and Service Employees International Union California State Council, who are plaintiffs-appellees in Ninth Circuit Case No. 09-16359, *Lydia Dominguez, et al. v. Arnold Schwarzenegger, et al.*

CORPORATE DISCLOSURE

Respondents have no parent corporations and no publicly held company owns any stock in these respondents.

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* Defendent-Appellant John Chiang, California State Controller, did not seek certiorari from the Court of Appeals decision. That not all the defendants bound by the preliminary injuction have petitioned for certiorari is an additional reason the petition should be denied.

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IN THE

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DAVID MAXWELL-JOLLY,
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On Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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BRIEF OF RESPONDENTS IN OPPOSITION

INTRODUCTION

According to Petitioners, the issues they raise are important enough to warrant a grant of certiorari because the Court of Appeals decisions at issue "ha[ve] made it virtually impossible" for States to curtail Medicaid expenditures by reducing provider rates. Pet. 35. To the contrary, however, the Court of Appeals has read the Medicaid Act correctly to impose a modest obligation upon participating States: that before reducing the rates paid to Medicaid providers, the relevant decision-maker must consider the impact such reductions will have upon Medicaid recipients' equal access to care and quality of care. That obligation does not prevent States from reducing Medicaid provider rates. The requirement in 42 U.S.C.

§1396a(a)(30)(A) that States must have "methods and procedures" to "assure" that Medicaid payments are sufficient to ensure equal access to care and quality of care necessarily precludes States from reducing payment rates solely for budgetary reasons and without consideration of the impact of those reductions.

As explained in further detail later in this brief, it is simply not true that the Court of Appeals decisions below require the legislature itself to conduct rate studies, to reference expressly any particular statutes, or to study non-existent provider costs. Moreover, Petitioners fail to acknowledge that the Court of Appeals did not simply find that their efforts in this case had fallen short, but that they had not *given any consideration whatsoever* to the impact of the cuts at issue before adopting them – and that they had waived any argument otherwise by failing to present it to the District Court. App. 79 (finding that "the State conceded that the legislature did not consider any analysis of the § 30(A) factors prior to enacting" SBX3 6 and so "waiv[ed] the issue").

Additional reasons counsel against certiorari in this case, including the interlocutory posture, the existence of substantial questions regarding whether factual and legal arguments were preserved below, and the fact that even without a federal cause of action Respondents could assert the same Medicaid claims at issue in state or federal court and obtain the same relief. The *Dominguez* Respondents also agree with the reasons for denying certiorari set forth in the briefs in opposition by the *California Pharmacists* and *Independent Living Center* Respondents.

STATEMENT

1. The In-Home Supportive Services ("IHSS") program provides assistance to enable low-income elderly, blind,

or disabled individuals to remain in the community rather than be forced into more costly nursing homes or other institutional settings. Cal. Welf. & Inst. Code § 12300(a); App. 63. Individuals are eligible for IHSS only if they "cannot safely remain in their homes or abodes of their own choosing unless these services are provided." Cal. Welf. & Inst. Code §12300(a); App. 162.

IHSS providers, who are paid by the State, deliver personal care services like bowel and bladder care, ambulation, bathing, oral hygiene, and feeding, as well as domestic and related services that permit IHSS recipients to live independently without compromising their health and safety. Cal. Welf. & Inst. Code § 12300(b)-(c); App. 63, 162-63. In some cases, the IHSS program also authorizes protective supervision for mentally impaired individuals and paramedical services such as the administration of medication and injections. Cal. Welf. & Inst. Code §§ 12300(b), 12300.1.

IHSS is provided through California's Medicaid program ("Medi-Cal"), and so program costs are shared by the federal government (which ordinarily is responsible for 50% of the costs but currently, pursuant to the federal stimulus legislation, covers 62%), state government (which pays two-thirds of the non-federal share), and county governments (which are responsible for the remaining one-third of the non-federal share). Cal. Welf. & Inst. Code §§ 12306(a)-(b), 12306.1(c); App. 62-63, 65 & n.2, 163-64.

The State has, by statute, established a system under which counties administer the IHSS program at the local level, and provider rates (wages and benefits) vary by county. Cal. Welf. & Inst. Code §§ 12301.6, 12302; App. 63-64. The state legislature sets a maximum rate toward which it will contribute ("rate cap"), counties submit proposed rates to the relevant state agencies, and the state

agencies approve those rates if they comply with federal and state law. Cal. Welf. & Inst. Code §§ 12306.1(a)-(d); App. 64-65.[1] State approval of county rates is contingent upon the State's maintenance of current funding levels (and so, according to prior communications by state officials, a reduction in the state cap automatically rescinds approval of all rates above that cap). Cal. Welf. & Inst. Code § 12306.1(b); App. 74.

IHSS recipients are responsible for finding and hiring their own providers. Cal. Welf. & Inst. Code § 12301.6(c). Some IHSS providers are related to their clients, but many consumers employ unrelated providers. Finding IHSS providers can be extremely difficult, given the nature of the work, which is often difficult and can be unpleasant. Some IHSS consumers are incontinent or unable to reach the bathroom when necessary. Others have mobility impairments and must be lifted and transferred by their providers. Still others have behavioral or mental health issues that make providing even basic services extremely challenging.

The California state legislature and state agencies have "recognize[d] that reimbursement rates – that is, providers' wages and benefits – are directly correlated to ensuring that services are consistent with efficiency, economy, and quality of care, and sufficient to ensure access to services under the IHSS program." App. 69; *see also* App. 73 & n.5. In other words, the relevant state officials have acknowledged that, the lower the reimbursement rates, the more difficult it is for IHSS recipients to find providers.

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[1] State law does not require counties to keep their rates at or below the rate cap. App. 66. Counties are, however, solely responsible for the full amount of the non-federal share of any amount above the rate cap. Cal. Welf. & Inst. Code § 12306.1(a); App. 66.

2. As a condition of participating in the Medicaid program, and thereby receiving federal Medicaid funds, the State of California has agreed to be bound by the provisions of the Medicaid Act, 42 U.S.C. §§ 1396a-1396v. Among the requirements imposed by that Act is that participating States adopt state Medicaid plans. *Id.*, § 1396. Those plans are themselves subject to a number of requirements, including that they must

> provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary . . . to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area . . . .

42 U.S.C. § 1396a(a)(30)(A) (hereinafter "Section 30(A)").

3. On February 20, 2009, the Governor signed SBX3 6 into law. App. 65, 218-27; S.B. 6, 2009-2010 Leg., 3d Extraordinary Sess. (Cal. 2009) (hereinafter "SBX3 6"). SBX3 6, which was enacted on an urgency basis and purely for budgetary reasons, would have reduced the IHSS rate cap by almost twenty percent, from $12.10 per hour to $10.10 per hour, effective July 1, 2009. App. 65, 219, 224, 227; SBX3 6 §9. Despite the commands of Section 30(A), the legislature decided to reduce the IHSS rate cap without any consideration of the Section 30(A) factors, including the impact that the reduction would have upon Medicaid recipients' equal access to IHSS services and the quality of those services. App. 79-80, 171.

Based on their position that SBX3 6 invalidated all existing rates above the new rate cap, state officials required all counties paying above $10.10 per hour to sub-

mit rate change requests for state approval. All county requests to reduce IHSS rates in response to SBX3 6 were approved. App. 66 & n.3, 74.

4. Respondents filed an action challenging SBX3 6 on May 26, 2009, asserting that the statute is preempted by Section 30(A) and violates the Americans with Disabilities Act and Section 504 of the Rehabilitation Act. App. 66-67 & n.4.

Respondents moved immediately for a preliminary injunction, and submitted substantial evidence that SBX3 6 would cause many providers who would be unable or unwilling to work for reduced wages to leave their jobs, and that many IHSS recipients would be unable to find replacement providers. For example, Respondent Leslie Gordon has severe cerebral palsy but is able to maintain an active and independent life in the community with the help of several IHSS providers, who lift her, assist her with bathing and toileting, and provide overnight care. Her providers submitted declarations that they would be forced to obtain other employment if their wages were reduced and that, given the difficulty of the tasks with which she needs assistance, Ms. Gordon would be unlikely to find providers to replace them at the lower wage. If she were unable to find a replacement provider, Ms. Gordon would be forced into a nursing home. Declarations of Leslie Gordon, Brittany Calhoun, and Natalie Hunter (D. Ct. Dkt. Nos. 14, 20, 24). Respondents also submitted expert testimony by, among others, labor economist Dr. Candace Howes, who used an economic model based on past documented responsiveness of provider turnover to wage fluctuations in order to estimate the increased turnover that would result from the rate reduction. She concluded that at least 4,000 IHSS recipients would lose their providers due to SBX3 6, 1,400 of whom would be forced into nursing homes due to inability

to find replacement providers, costing the State tens of millions of dollars in increased expenditures. Declaration of Dr. Candace Howes (D. Ct. Dkt. No. 22).

On June 25, 2009, the District Court enjoined implementation of SBX3 6's rate cap reduction on the ground that Respondents had shown a likelihood of success on the claim that the State had violated the procedural requirements of the Medicaid Act. App. 162. The court found that Petitioners had "concede[d] that the California legislature did not consider the Section 30(A) factors" – that is, "the impact of the provision on access to care or the quality of care" – when it adopted SBX3 6. App. 171. And the court rejected Petitioners' contention that the State was not responsible for Section 30(A) compliance with respect to the IHSS program. App. 168-172.

The District Court also concluded that IHSS recipients would "suffer immediate and irreparable harm" without an injunction, and that the challenged statute would "greatly diminish[]" IHSS recipients' quality of life. App. 172-73. Specifically, the District Court concluded that "[t]he wage reductions w[ould] cause many IHSS providers to leave employment, which in turn w[ould] leave consumers without IHSS assistance," and cited expert testimony as well as other evidence that without IHSS recipients would go hungry; suffer dehydration, falls, and burns; be unable to leave their homes; and/or face unnecessary institutionalization.

The District Court also found "persuasive evidence that the wage cuts will actually *cost* the State *tens of millions of additional dollars* because in-home care is considerably less expensive than institutionalized care and IHSS providers reduce the need for expensive emergency room visits." App. 174 (emphasis added). That is, although the State refers repeatedly to budget issues, the evidence before the District Court established that implementation

of the state statute at issue actually would have required greater State expenditures.

Both the District Court and the Court of Appeals denied Petitioners' requests for stays pending appeal. Supp. App. 1a, 8a. After Petitioners repeatedly refused to restore rates to pre-SBX3 6 levels, the District Court issued two further injunctions prohibiting Petitioners from putting into effect wage reductions based on SBX3 6. Supp. App. 2a-7a; App. 180-189.

Petitioners appealed, and the Court of Appeals affirmed in a unanimous decision. The Court of Appeals found that Petitioners had conceded, in the District Court, "that the legislature did not consider any analysis of the § 30(A) factors prior to enacting" SBX3 6, and had waived any claim to the contrary. App. 79. In any event, the court concluded, the annual report that Petitioners now asserted fulfilled the State's Section 30(A) obligation did not purport to analyze the effect of any rate decrease, and in fact had documented a "'critical shortage of available providers'" for groups of IHSS recipients in almost half of all counties. App. 80.[2] And the Court of Appeals rejected Petitioners' various arguments as to why the Section 30(A) obligation would not apply in the IHSS context. App. 70-75, 76-79.

The Court of Appeals also affirmed the District Court's findings of irreparable harm and that equitable factors favored an injunction, "especially in light of evidence in the record that suggests that reductions in providers' wages and benefits may have an adverse, rather than beneficial, effect on the State's budget, such that it would

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[2] That report was in the District Court record but had been cited for other purposes; Petitioners had not argued, before the appeal, that the legislature had considered the report in connection with the enactment of SBX3 6.

actually *save the State money* if it maintained its current level of funding of the IHSS program." App. 80-83 (emphasis added). And it emphasized that the State remains free to "make[] a policy decision to decrease providers' reimbursement rates" so long as it complies with the requirements of the Medicaid Act in doing so. App. 82-83.

REASONS THE PETITION SHOULD BE DENIED

The *Dominguez* Respondents agree with the discussion in the briefs in opposition filed by the *Independent Living Center* and *California Pharmacists* Respondents as to why the Court of Appeals correctly decided the cases below, and why the Court of Appeals decisions present no conflict with those by other circuits or state courts. Rather than repeating those arguments, Respondents join in them fully, and set forth herein the following additional reasons why certiorari should be denied.

1. The Petition's Characterization of the Proceedings and Holdings Below Is Inaccurate, and Fails to Acknowledge Petitioners' Concession that the State Gave No Consideration to the Section 30(A) Factors Before the Decision to Reduce Rates.

Petitioners contend that,"[b]y adopting inconsistent, ever-expanding, ever-more-detailed rules, the Ninth Circuit has made it virtually impossible for California to enact a statute that . . . may reduce reimbursements to Medicaid providers." App. 35. This misreads the relevant decisions below.[3]

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[3] Petitioners also omit mention of the Court of Appeals' and District Court's findings, on the record established at the time of the preliminary injunction, that the reduction of IHSS provider rates would cost the State more money than it would save because of increased institutionalization costs. *See supra* at 7, 8-9.

It is not the case that Petitioners have repeatedly attempted to comply with the obligations of Section 30(A) but been thwarted by increasingly specific and unreasonable judicial rejections of those efforts. Rather, as the Court of Appeals explained, Petitioners have "conceded that the legislature did not consider *any analysis of the § 30(A) factors* prior to enacting § 12306.1(d)(6)," and waived any argument otherwise. App. 79 (emphasis added).[4] The Court of Appeals did go on to reject Petitioners' *post hoc* explanation that the legislature might have relied upon an annual report produced by the California Department of Social Services regarding the state of the IHSS program, but not because that report failed to meet technical or detailed requirements. Rather, the Court of Appeals accurately observed that the report did not even mention, much less purport to analyze the effect of, any rate reduction. App. 80. Further, the court noted that the report documented critical shortages of IHSS providers – and so inconsistency with the Section 30(A) factors – in certain counties even at the higher, pre-SBX3 6 rates. App. 80; *compare* App. 20-21.

Petitioners erroneously contend that the Court of Appeals held that the state legislature itself, rather than a state agency, must conduct the study of the Section 30(A) factors when the legislature acts to reduce rates. Pet. 5, 31 (citing App. 13-14, 16, 54). In fact, in rejecting Petitioners' arguments that the legislature had relied on studies commissioned or conducted by a state agency, the Court of Appeals did *not* say that the legislature itself must conduct the study. *See also Orthopaedic Hospital*, 103 F.3d at 1496 (holding that state agency – which set the

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[4] Over a decade ago, the Court of Appeals rejected the State's argument that Section 30(A) did not require consideration of the impact of a rate reduction upon access to or quality of Medicaid services. *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491, 1496 (9th Cir. 1997).

rates at issue in that case – was required to consider cost studies, "its own or others'"). Rather, the court said that the studies at issue were inadequate because they did not analyze the effect of the rate reductions at issue upon access or quality, and that there was no evidence the legislature had considered the studies in enacting those rate reductions. App. 55-56, 80. Consideration of the impact of a rate reduction by someone other than the entity that is actually making the decision to reduce rates would carry out neither the mandate nor the purposes of Section 30(A).[5]

Petitioners go on to assert that under the Court of Appeals' rulings a study of the Section 30(A) factors "must *expressly reference both § 1396a(a)(30)(A) and the specific statutory enactment* at issue," so that a study upon which the legislature could otherwise rely, but that fails to make those express references, would not suffice. Pet. 5, 32 (citing App. 20, 56, 80) (emphasis in original). But the Court of Appeals held no such thing; rather, it rejected Petitioners' attempt to rely upon studies or reports that did not address the contemplated rate reduction and either did not analyze the relevant factors or con-

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[5] Similarly, consideration of the impact of a rate reduction upon access and quality *after* the final decision to reduce rates has been made would be an empty exercise. Petitioners complain that the Court of Appeals held that the required analysis must be conducted before enacting the reduction, rather than post-enactment but prior to implementation. Pet. 4, 31 (citing App. 15, 54, 57, 80). But the Court of Appeals did not reject Petitioners' contention that, if the implementing agency had the authority to decline to implement the rate reduction based on a study of the Section 30(A) factors, then a post-enactment but pre-implementation study would fulfill the State's obligations; rather, it concluded that the agency had no authority but to implement the rate reduction at issue unless the federal government actually withheld funds from the State. App. 21-29. Since the legislature was the body that decided to reduce rates, it was required to consider the Section 30(A) factors. App. 22, 28.

cluded that *current* rates, prior to a contemplated reduction, produced significant problems with access and quality. For example, in *Dominguez*, the Court of Appeals found that the annual report that Petitioners asserted fulfilled the Section 30(A) obligation "contains no discussion of a contemplated rate change that would either increase or decrease payment rates," and in fact documents a "'critical shortage of available providers that affected a specific subpopulation of IHSS consumers'" in almost half of the counties statewide. App. 80; *see also* App. 20 (in *California Pharmacists*, noting one analysis "is concerned solely with budgetary matters" and does not mention Section 30(A) factors at all, and that other finds that greater rate reduction would limit recipient access to services); App. 55-56 (in *Independent Living Center*, noting report does not analyze access or quality at all, and that it recommends further analysis in light of its conclusions about provider costs).[5]

Finally, Petitioners contend that the Court of Appeals held that even when a group of providers does not incur costs the State must study provider costs. Pet. 5, 32 (App. 78-79). That is not true. The Court of Appeals held merely that the State "must rely on something" to determine the impact of a rate reduction upon access

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[5] Relatedly, Petitioners contend that, under the Court of Appeals decisions, a mention on a legislative committee agenda does not suffice to show that the legislature considered a study. Pet. 5, 32 (citing App. 55-56). In fact, however, Petitioners had not argued, in the District Court or in their appellate briefs, that the legislature had considered the study at issue – rather, they waited until the appellate oral argument to make this assertion. App. 54-55. Moreover, the Court of Appeals noted that the study at issue did not analyze the impact of a rate reduction upon access or quality, and found no clear error in the District Court's finding that the Section 30(A) factors were not considered by the legislature prior to its decision to reduce rates. App. 55-56.

to and quality of care, and suggested that the State could consider factors like those presented in an annual report issued by the relevant state agency. App. 78.[7] Then, the court went on to note that, in addition, the State "may" look at costs for providers of analogous services, or to the market rate for similar work in the local area. App. 79. In no way did the court require analysis of non-existent costs.[8]

Despite Section 30(A)'s requirements, for the past two years, the State of California has repeatedly made across-the-board reductions in Medicaid provider rates based solely upon budgetary considerations, and without any (much less adequate) consideration of the impact of such reductions upon the Section 30(A) factors. Petitioners

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[7] That annual report was held inadequate to satisfy the State's Section 30(A) obligations not because it failed to consider provider costs, but because it did not analyze the effect of the rate change at issue and found substantial access problems even before the reduction in rates. App. 80. Moreover, Petitioners had waived any argument that the legislature had actually considered the annual report in enacting the rate reduction. App. 79.

[8] Petitioners also contend that the Court of Appeals held that the Section 30(A) obligation extends to any statute that could potentially affect provider rates. Pet. 38. That is a broad overreading of the Court of Appeals' holding. In relation to IHSS, the State, which is bound by its participation in Medicaid to ensure compliance with Section 30(A), has established a rate-setting system under which its role is to establish the rate cap and to approve individual county rates. *Supra* at 3-4. The Court of Appeals found not that the rate cap enacted by SBX3 6 might possibly affect rates in the future, but that it directly and immediately drove rate reductions in the affected counties. App. 72. State officials themselves had represented that the enactment of SBX3 6 automatically rescinded approval of existing rates above the new, lower rate cap, and so "the State explicitly invalidated its prior approval of [these] rates . . . as a result of" SBX3 6. App. 74. There can be no question that, if Section 30(A) requires consideration of access and quality in providing for the methods of payment, that obligation was implicated by SBX3 6.

have advanced varying and at times contrary views on whether the Section 30(A) factors were considered at all, and if so, by which entity and at which time.

In the instant case, for example, Petitioners conceded in the trial court that the legislature had given no consideration to the Section 30(A) factors before reducing provider payments. App. 79, 171. Then, on appeal, Petitioners asserted for the first time that the Section 30(A) obligation had been met by an annual report prepared by the state agency.[9] The Court of Appeals found that Petitioners' failure to make this argument below waived it, and so the court's explanation as to why the study did not fulfill the State's Section 30(A) obligations – that it documented serious access problems and did not purport to analyze the impact of reductions in provider payments – were in the nature of alternative holdings only. App. 80. Similarly, in *California Pharmacists*, Petitioners argued for the first time in their reply brief on appeal that the state agency's consideration of a study after the legislature's enactment of the rate reductions sufficed to fulfill the State's Section 30(A) obligation, because the agency had the discretion not to implement the rate reductions adopted by the state legislature, and the Court of Appeals found that argument had been waived. App. 22-24. The Court of Appeals went on to reject both the notion that the agency had such discretion, and Petitioners' argument that the study would have fulfilled the Section 30(A) obligation, but only as alternate grounds for its conclusion that the State had not met its obligation. App. 24-29 & nn. 4-5. And in *Independent Living Center*, Petitioners waited until their oral argument on appeal to assert that the *legislature* had relied upon that same cost study. App. 54-55.

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[9] The study was in the trial court record because Petitioners had relied upon it for a different point.

It is not the Court of Appeals' "onerous" requirements that have prevented the State from reducing Medicaid rates. Pet. 7; *see* App. 82-83 ("If the State makes a policy decision to decrease providers' reimbursement rates, and fully complies with the requirements of this and our other decisions, it will not be barred by current federal Medicaid law from doing so."). Rather, it is the State's own failure to consider the Section 30(A) factors at all when reducing Medicaid rates. Petitioners' failure to take any steps to evaluate the impact of the rate reductions at issue upon equal access to and quality of care before those rate reductions were enacted would make these cases poor vehicles for resolving the nature of any obligation under Medicaid Section 30(A) that does exist.

2. The Interlocutory Posture and Questions Regarding Issue Preservation Counsel Against Certiorari.

As is true of the other two cases at issue in the instant petition, the decision by the Court of Appeals affirms a preliminary injunction and is therefore necessarily interlocutory in nature, which itself is reason to deny certiorari. *See Brotherhood of Locomotive Firemen v. Bangor & Aroostock R. Co.*, 389 U.S. 327, 328 (1967); *Hamilton-Brown Shoe Co. v. Wolf Bros. & Co.*, 240 U.S. 251, 258 (1916); *American Constr. Co. v. Jacksonville, T. & K.W. Ry. Co.*, 148 U.S. 372, 384 (1893).

If this Court declines to review these interlocutory decisions, Petitioners will be able to seek review of final judgments in these proceedings at the appropriate time. In all three cases, proceedings in the District Court are ongoing. In the instant case, the hearing on dispositive motions is set for March 3, 2011 and trial is scheduled on June 6, 2011.[10] This Court will have ample opportunity to

[10] These proceedings will also adjudicate Respondents' claims under the Americans with Disabilities Act and the Rehabilitation Act that SBX3 6 will cause unnecessary institutionalization of IHSS

review the final judgment that results from those proceedings in the near future.

There are strong reasons to wait for a final judgment rather than reviewing the interlocutory decisions below. In the current cases, disputes abound as to which evidence and arguments were properly before the courts below when the preliminary injunctions at issue were entered and affirmed. For example, in the instant case, the District Court and Court of Appeals both found that Petitioners had conceded that the legislature did not give any consideration to the Section 30(A) factors before enacting SBX3 6. App. 79, 171. Yet Petitioners now seek to contest that fact. Similarly, in *California Pharmacists*, Petitioners waived the argument that the state agency rather than the state legislature was the relevant rate-setting entity, but have since changed their minds on that front. App. 22-24. Rather than attempt to sort out which factual and legal issues were properly raised and when, this Court should wait to determine whether certiorari is warranted until after final judgments have been rendered.

3. Resolution of the Questions Presented Will Not Affect the Result in this Case.

a. Resolution of the First Question Presented Would Not Affect the Authority of Federal or State Courts to Entertain Similar Preemption Claims.

Resolution of the first Question Presented will not have any real world impact upon Petitioners' obligation to com-

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recipients whose providers quit work and who cannot find replacement providers. *See Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 587 (1999). If the District Court grants judgment in favor of Respondents on these claims, the preliminary injunction affirmed by the Court of Appeals will be rendered moot, and the Court of Appeals decision regarding Respondents' likelihood of success on the Medicaid Act claim will become superfluous.

ply with Section 30(A). In California, California Code of Civil Procedure Section 1085 authorizes a private party to enforce state officials' obligations to comply with the Medicaid Act (or any other federal statute) through a petition for writ of mandate, regardless of whether the statutory provision is enforceable via 42 U.S.C. § 1983. *See Mission Hosp. Regional Med. Ctr. v. Shewry*, 168 Cal.App.4th 460, 478-79 (2008); *California Ass'n for Health Servs. at Home v. Department of Health Servs.*, 148 Cal.App.4th 696, 706 (2007); *Doctor's Med. Lab., Inc. v. Connell*, 69 Cal.App.4th 891,896 (1999).[11]

Thus, even if Petitioners were to prevail on their first Question Presented, Respondents could raise the same claims in state court via a mandamus action, or could potentially assert them in federal court to the extent that their disposition would turn upon the resolution of a contested and substantial question of federal law. *See Grable & Sons Metal Prods., Inc. v. Darue Eng'g & Mfg.*, 545 U.S. 308, 312-13 (2005).[12]

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[11] In support of a related certiorari petition, Petitioners suggested that a successful mandamus action in California requires the existence of a statutory "right" akin to the type of right that is enforceable under 42 U.S.C. § 1983. Reply Brief in Support of Petition for Writ of Certiorari, No. 09-958 (filed Apr. 30, 2010) at 9. They well know this is not true. California courts have made clear that any party with a beneficial interest may file a mandamus action to compel state officials to follow the law and that "[t]he beneficial interest standard is so broad, even citizen or taxpayer standing may be sufficient to obtain relief in mandamus." *Mission Hosp.*, 168 Cal.App.4th at 480. A writ of mandate to enforce a legal duty "is available not only to those who have enforceable private rights," but to anyone who is a "beneficially interested" party – meaning that they have an interest that is different from the public at large. *Id.* at 479-80 (internal quotation marks and citations omitted). All that is needed to establish such a beneficial interest is an injury akin to that required to establish Article III standing. *California Ass'n for Health Servs. at Home*, 148 Cal.App.4th at 706-07.

[12] In the instant case, Respondents could also rely upon supplemental federal jurisdiction, based on the Americans with Disabilities Act and Rehabilitation Act claims asserted in the case.

b. Resolution of the Second Question Presented Would Not Affect the Outcome of the Case Because Even Under Petitioners' Reading of Section 30(A) the State's Enactments Are Preempted.

Petitioners take the position that Section 30(A) establishes "substantive" rather than procedural obligations, and may require "that rates not be set . . . so low as to create an access or quality of care problem for beneficiaries." Reply Brief in Support of Petition for Writ of Certiorari, No. 09-958 (filed Apr. 30, 2010) at 9-10; Petition for Writ of Certiorari, No. 09-958 (filed Feb. 16, 2010) at 33; *see also id.* at 26 (Section 30(A) "arguably sets some substantive objectives – that rates not be set . . . so low as to create an access or quality of care problem for beneficiaries"); *id.* at 31 (criticizing Court of Appeals for failing to determine whether new rates meet "substantive requirements" of statute).[13]

The Court of Appeals' holding comports with the mandates of Section 30(A), which requires States to have "methods and procedures" to ensure that payments are consistent with, among other factors, access and quality. 42 U.S.C. § 1396a(a)(30)(A). But even if Section 30(A) were to impose a substantive rather than procedural obligation, the rate reduction at issue still would be invalid. The Court of Appeals found that "both the legislature and the Department recognize that reimbursement rates . . . are directly correlated to ensuring that services are consistent with . . . quality of care, and sufficient to ensure access to services under the IHSS program." App. 69.

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[13] The Court of Appeals has previously explained that the substantive approach favored by Petitioners accords *less* deference to the State in making decisions about provider rates than the procedural reading of Section 30(A). *See Independent Living Center of S. Cal. Inc. v. Shewry*, 572 F.3d 644, 657 (9th Cir. 2009).

And it observed that Petitioners themselves sought to rely on a report that documented a "critical shortage of available providers" affecting specific subgroups of IHSS recipients in almost half of the counties statewide, thus "bel[ying] the State's assertion that current wages and benefits – those in effect prior to passage of [SBX3 6] – are consistent with § 30(A)'s statutory factors." App. 80. Further, the Court of Appeal accepted the District Court's findings that reductions in provider rates would lead to institutionalization of Medicaid recipients whose providers would cease providing services and who would be unable to find replacements. App. 82; *see also* App. 172-74 (District Court findings that rate reductions "will cause many IHSS providers to leave employment, which in turn will leave consumers without IHSS assistance," reduce quality of care, and lead to institutionalization).

Accordingly, a ruling for Petitioners on the merits of the Second Question Presented would not affect the result in this case, because the SBX3 6 rates would not be valid under the Respondents' proposed reading of Section 30(a).[11] The Court of Appeals reached similar conclusions regarding the impact of the rate reduction at issue upon recipients' access to Medicaid services in the *California Pharmacists* and *Independent Living Center* cases as well. App. 33-34 ("[E]ven if we were to require a substantive violation of the statute to support a finding of irreparable harm, we would find that violation here" based on showing that recipients will lose access to adult day health services); App. 57-58 (affirming district court

[11] In addition, the findings of the District Court and Court of Appeals that the rate reductions would lead to unnecessary institutionalization would establish Respondents' entitlement to an injunction based on Petitioners' claims under the Americans with Disabilities Act and Rehabilitation Act. *See supra* at 7, 8-9.

findings that reduction in rates will limit Medi-Cal patients' access to pharmacy services).

CONCLUSION

For the reasons discussed, this Court should deny certiorari.

RECORD AND BRIEFS

No. 09-1158

FEB 7 - 2010

In the
Supreme Court of the United States

DAVID MAXWELL-JOLLY, Director of the Department of Health Care Services, State of California, et al.,

Petitioners,

v.

CALIFORNIA PHARMACISTS ASSOCIATION, et al.,

Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

REPLY BRIEF IN SUPPORT OF PETITION FOR A WRIT OF CERTIORARI

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REPLY BRIEF FOR PETITIONERS

This petition raises the same questions posed in *Maxwell-Jolly v. Independent Living Center of Southern California*, No. 09-958: whether private parties may invoke the Supremacy Clause to enforce a Medicaid statute, 42 U.S.C. § 1396a(a)(30)(A), that does not meet the requirements for private enforcement identified in *Gonzaga University v. Doe*, 536 U.S. 273 (2002) and other cases; and whether courts may enjoin state Medicaid reforms based on entirely atextual requirements.

On May 24, 2010, the Court invited the Solicitor General to file a brief expressing the views of the United States in *Independent Living*. At minimum, the Court should issue a similar invitation here in order to identify the best vehicle for these issues. If *Independent Living* merits such consideration, then *a fortiorari* so do the more expansive holdings at issue here.

Respondents' oppositions offer little that is new beyond misstatements of what the Ninth Circuit held in the present cases (*Cal. Pharm. II* and *III*, *Indep. Living IV*, *Dominguez*) and unsupported and irrelevant assertions, as addressed below.

I. The Court Should Review the First Question Presented

The Court should review whether a private party may enforce a Spending Clause statute that does not

satisfy the traditional requirements for private enforcement.

1. This Court has long held that Congress must create "private rights of action to enforce federal law." *Alexander v. Sandoval*, 532 U.S. 275, 286 (2001). Without Congressional intent to permit private enforcement, "a cause of action does not exist and courts may not create one, no matter how desirable that might be as a policy matter, or how compatible with the statute." *Id.* at 286-87. Because Congress does not always state its intentions, this Court has developed tests for determining when such a cause of action may be implied, *Cort v. Ash*, 422 U.S. 66 (1975), or authorized under § 1983. *Gonzaga*, 536 U.S. at 283-86.[1]

Under the foregoing precedents, the present case is an easy one. Applying *Gonzaga*, the Ninth and several other circuits have held that the text and structure of § 1396a(a)(30)(A) do not evince Congressional intent to create privately enforceable "rights." *See, e.g., Sanchez v. Johnson*, 416 F.3d 1051 (9th Cir. 2005); *Long Term Care Pharmacy Alliance v. Ferguson*, 362 F.3d 50, 58 (1st Cir. 2004) (agency review is "central means of enforcement"). To circumvent this law, the present cases are styled as "preemption" claims, but

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[1] Given these precedents, petitioners have never contended that "express statements by Congress [are required] to create an implied private right of action." *See* Independent Living IV Opp. at 21.

preemption *also* turns on Congressional intent. *Wyeth v. Levine*, 129 S. Ct. 1187, 1194 (2009). Further, in contrast to some other constitutional provisions, the Supremacy Clause does not create a right of action. *Dennis v. Higgins*, 498 U.S. 439, 450 (1991).

2. Respondents dispute, for the first time in this litigation, evidence that Congress intended to preclude private suits when it repealed the Boren Amendment. Cal. Pharm. Opp. at 22. However, the language in the cited committee report is not limited to amended § 1396a(a)(13)(A), but encompasses "any other provision of [§ 1396a]." H.R. Rep. No. 105-149, at 591 (1997). For this reason, numerous courts construing § 1396a(a)(30)(A) have cited this language, along with the text and structure of the statute itself, when denying private efforts to enforce § 1396a(a)(30)(A).[2]

Respondents cite inapposite decisions from this Court in order to cast their Supremacy Clause-based claim as well-established. Petitioner Maxwell-Jolly addressed these and related arguments fully in *Independent Living*, No. 09-958. Respondents cite Justice Kennedy's dissent in *Golden State Transit*

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[2] *Pa. Pharmacists Ass'n v. Houstoun*, 283 F.3d 531, 540 n.15 (3d Cir. 2002); *Evergreen Presbyterian Ministries Inc. v. Hood*, 235 F.3d 908, 929 n.26 (5th Cir. 2000), *overruled in part on different grounds, Equal Access for El Paso, Inc. v. Hawkins*, 509 F.3d 697 (5th Cir. 2007); *Bio-Medical Applications of NC, Inc. v. Elec. Data Sys.*, 412 F. Supp. 2d 549, 554-55 (E.D.N.C. 2006); *Burlington United Methodist Family Servs., Inc. v. Atkins*, 227 F. Supp. 2d 593, 596 n.3 (S.D.W.Va. 2002).

Corp. v. City of Los Angeles, 493 U.S. 103, 113 (1989), which recognized that "a private party can assert an immunity from state or local regulation on the ground that the Constitution or a federal statute, or both, allocate the power to enact the regulation to the National Government, to the exclusion of the States." However, respondents here are not invoking preemption defensively as an immunity from regulation, but offensively to create a stand-alone cause of action.

3. Confusion and conflict among the circuits support review, including several circuits' misapplication of this Court's precedent and their erroneous belief that this Court already has reached the question presented. Pet. at 7. Far from "abandoning" an argument that a split exists with the Eleventh Circuit, petitioner Maxwell-Jolly reiterated it just last month. *Independent Living*, No. 09-958, Reply Brief at 7.

4. Respondents' "vehicle" argument mischaracterizes mandamus law in California and petitioner Maxwell-Jolly's prior briefing. In *Independent Living*, petitioner Maxwell-Jolly accurately cited a leading California treatise and a California Supreme Court decision for two propositions: (1) mandamus requires that petitioner have a "clear, present, and beneficial right . . . to the performance of" a (ministerial) duty; and (2) "mandamus can give no right . . . although it may enforce one." It is true, as respondents note, that some intermediate state appellate decisions have allowed enforcement under the mandamus statute, Cal. Code. Civ. Proc. § 1085, of federal statutes that are not enforceable under § 1983. The California

Supreme Court has not reached this issue, however, and no published California appellate opinion has addressed the enforceability of § 1396a(a)(30)(A), a provision which, properly construed, neither confers "rights" nor imposes "ministerial" duties.[3] Moreover, § 1085 may be preempted if it is construed to permit private enforcement of § 1396a(a)(30)(A) in contravention of Congressional intent.

II. The Court Should Review the Second Question Presented

The Court also should review whether a court may enjoin a state law for failure to comply with purported requirements in a Spending Clause statute that neither Congress nor any federal agency created.

1. The Ninth Circuit has added new requirements to § 1396a(a)(30)(A) in a series of decisions. First, the court created a "study" requirement and mandated that Medicaid payments reflect provider costs. *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491 (9th Cir. 1997), *cert. denied*, 522 U.S. 1044 (1998). Then, in the six opinions at issue here and in *Independent*

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[3] In *CAHF v. DHS*, No. A107551, 2006 WL 3775842 (Cal. Ct. App. Dec. 26, 2006), the court construed an "add-on" provision unique to California's state plan. The court's observations regarding § 1396a(a)(30)(A) are dicta, and *California Pharmacists* respondents' citation to this unpublished decision violates rule 8.1115 of the California Rules of Court (unpublished opinion "must not be cited or relied on"). The Court of Appeal denied CAHF's publication request.

Living, No. 09-958, it added requirements as to *who* must conduct the study; *what* the study must say; on what type of *data* the study must rely; and *when* the study must occur.[4] As these requirements do not appear in § 1396a(a)(30)(A), the Ninth Circuit's approach "more closely resembles 'invent[ing] a statute rather than interpret[ing] one.'" *Hardt v. Reliance Standard Life Ins. Co.*, No. 09-448, ___ U.S. ___, 2010 WL 2025127, at *7 (U.S. May 24, 2010).

The Ninth Circuit's revisions conflict with Congressional intent. Congress *used* to require states to "*find[], and make[] assurances*" that Medicaid payments were "reasonable and adequate to *meet the costs* . . . incurred by efficiently and economically operated" providers. *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 503 (1990) (emphasis added). Congress repealed the Boren Amendment to increase states' flexibility in running their Medicaid programs and because it was concerned about the proliferation of private lawsuits challenging Medicaid rates. *Evergreen*, 235 F.3d at 919 n.12; Brief for the United States as Amicus Curiae, *Belshe v. Orthopaedic Hosp.*, No. 96-1742 (S. Ct. Nov. 26, 1997), 1997 WL 33561790. However, the Ninth Circuit has made it harder for states to improve efficiency and economy in their Medicaid programs, and has invited even more lawsuits. And it has added requirements to

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[4] Respondents contend these requirements are "textually-rooted," Cal. Pharm. Opp. at 26, but never identify the alleged text.

§ 1396a(a)(30)(A) that are very similar to, though more onerous than, those Congress purposefully eliminated from § 1396a(a)(13)(A), including a requirement of cost-based rates that the United States agrees does not exist. Brief of the United States, *supra*.

Respondents say that the atextual "goalposts" are not "moving," but the Ninth Circuit opinions speak for themselves. Moreover, respondents do not dispute that, under *Orthopaedic*, 103 F.3d at 1494, the State was allowed to implement the rates while a study was being conducted – an approach that conflicts irreconcilably with the court's current rejection of several formal, pre-implementation studies prepared by DHCS.

Respondents say that Ninth Circuit is not "overreaching." However, when a court repeatedly takes for itself functions delegated to other branches – here, both Congress (responsibility for drafting statutes and determining who may enforce them) *and* the executive (responsibility for enforcing federal laws) – it has overreached.[5]

2.a. Respondents assert that the Ninth Circuit grounded preemption of the AB1183 reductions (but not SB6) on an alternative finding that the California "legislature . . . was concerned 'solely with budgetary

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[5] *California Pharmacists* respondents' description of interactions between the State and the Ninth Circuit panel is not only irrelevant, but highly selective and misleading.

matters'" when it enacted those reductions. Cal. Pharm. Opp. 10, 24-25; *see also* Independent Living IV Opp. at 7, 26-27; Dominguez Opp. at 13. But the portion of the Ninth Circuit opinion to which respondents selectively quote did not make such a finding of the Legislature's (purportedly) improper intent. It merely described the documentary evidence before the trial court, which the court held inadequate because, *inter alia* it did not expressly mention the §1396a(a)(30)(A) factors. Pet. App. 20 ("The legislative history nowhere mentions any of the §30(A) factors . . . and is concerned solely with budgetary matters.").

That the legislative history did not expressly mention § 1396a(a)(30)(A) is understandable given the law at the time. When the Legislature deliberated, the courts had not yet created (or affirmed) the new atextual requirements. Thus, the Legislature could not know that the courts would construe § 1396a(a)(30)(A) to impose duties directly onto it, complete with specific study and express documentation requirements, and that it could not rely on DHCS (the single state agency designated to implement Medi-Cal, 42 U.S.C. § 1396a(a)(5); Cal. Welf. & Inst. Code § 10740) to discharge them. And that is the problem: a state cannot comply with the terms of its contract with the federal government if it does not know what those terms will be until a court announces them, *see Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17-18 (1981), let alone if a

court can modify or expand those terms with each new decision.

In any event, § 1396a(a)(30)(A) does not prohibit a state from considering "budgetary matters" when adjusting rates. To the contrary, it *requires* such consideration, at least to the extent that it directs states to adopt "methods and procedures" in their state plans to assure, *inter alia*, the "efficiency" and "economy" of their payments.[6] Moreover, it would be irresponsible for California *not* to consider "budgetary matters" when analyzing the billions of dollars in Medicaid payments it makes each year.

Respondents characterize the nuanced (i.e., 1%, 5% and 10%) reductions in AB1183 as "across-the-board," "arbitrary," and wholly budget-driven. This ignores the months of legislative deliberation that preceded their enactment. And it ignores DHCS's findings in its formal reports that, after the reductions, rates would be reasonable relative to providers' costs; many providers would be reimbursed substantially in excess of their costs; and Medi-Cal recipients would continue to have adequate access to covered services. Pet. at 10-16, 20-21.

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[6] Respondents sometimes omit references to the "state plan" when they quote § 1396a(a)(30)(A), as if to imply that the statute imposes requirements directly on the Legislature, *see, e.g.*, Dominguez Opp. at 2, 18, but, by its terms, § 1396a(a)(30)(A) imposes no substantive requirements beyond those relating to the contents of a state plan.

b. Respondents argue that review should be denied because, at least with respect to the ADHC reductions, the Ninth Circuit found a separate "substantive" violation of § 1396a(a)(30)(A) based on DHCS's concession that "at least some ADHC Medi-Cal providers would stop treating beneficiaries due to AB1183." *See* App. at 33; Cal. Pharm. Opp. at 25. But, this is the wrong legal standard; § 1396a(a)(30)(A) is not concerned with whether some providers may leave Medicaid (or suffer financial injury), but rather whether sufficient providers will remain.[7] Contrary to respondents' arguments, the Ninth Circuit did not hold there were "substantive" violations with respect to the other reductions. *See, e.g.*, Pet. App. 76 (plaintiffs not required to show "a substantive violation").

c. Respondents argue that the formal AB1183 studies conducted by DHCS were inadequate because DHCS lacked discretion not to implement the reductions after the Legislature had acted. But, had the studies demonstrated a violation that DHCS could not address itself, it would have asked the Legislature for relief, which would have acted to comply with the law. *Alden v. Maine*, 527 U.S. 706, 755 (1999) ("We are unwilling to assume the States will refuse to honor . . . or obey the binding laws of the United States.").

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[7] DHCS's formal report documented that Medi-Cal recipeents had far greater access to ADHC services than the general population.

d. Respondents argue that petitioners waived arguments in the trial courts that two studies (Myers and Stauffer, DSS) operated to discharge duties on the Legislature to study the enactments challenged in *Dominguez* and *Independent Living IV*.[8] Respondents acknowledge, however, that on appeal petitioners raised and the Ninth Circuit passed on these very arguments. Pet. App. 55-57, 79-80. And respondents do not dispute that petitioners preserved the larger, purely legal issue of whether § 1396a(a)(30)(A) imposes any duties whatsoever on the Legislature. Given the state of law at the time the evidence was introduced, respondents' waiver arguments demonstrate only that a state's attorneys may fare no better than its legislature at anticipating atextual requirements before they are announced.[9]

3. While respondents dispute that a circuit split exists, their main support is the Ninth Circuit's *own* assertion that its decision was "'consistent with that of [other] circuits.'" Cal. Pharm. Opp. at 9-10. The

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[8] *Dominguez* does not even involve state rate-setting. Respondents dispute this based on the fact that, after SB6 was enacted, petitioners directed the counties to submit new rate packages, Dominguez Opp. at 5, but petitioners only took action to ensure that the packages accurately reflected, *inter alia*, any change in the State's contribution to the counties' rates.

[9] While petitioners conceded in oral argument in *Dominguez* that the Legislature did not expressly consider the § 1396a(a)(30)(A) factors, they did not concede that the Legislature's action lacked foundation or failed to meet any standards imposed by § 1396a(a)(30)(A).

Ninth Circuit stands alone in every aspect of its multiple holdings regarding § 1396a(a)(30)(A). *See Long Term Care*, 362 F.3d 50; *Rite Aid of Pa., Inc. v. Houstoun*, 171 F.3d 842 (3d Cir. 1999); *Evergreen*, 235 F.3d 908; *Methodist Hosps., Inc. v. Sullivan*, 91 F.3d 1026 (7th Cir. 1996); *Minn. HomeCare Ass'n v. Gomez*, 108 F.3d 917 (8th Cir. 1997). Even the Eighth Circuit has expressly rejected that a "study" requirement exists when a state legislature enacts a rate reduction, citing the natural give-and-take of the legislative process. *Compare Minn. HomeCare Ass'n*, 108 F.3d at 918 *with Arkansas Med. Soc'y, Inc. v. Reynolds*, 6 F.3d 519 (8th Cir. 1993).

4. Recent events further support review. On May 27, 2010, the Ninth Circuit held that, even where a state statute expressly sets reimbursement rates at a specific percentage of providers' costs, the Legislature *still* must do a "cost study." *Santa Rosa Mem'l Hosp. v. Maxwell-Jolly*, No. 09-17633, 2010 WL 2124276 (9th Cir. May 27, 2010). Since this petition was filed, at least three new § 1396a(a)(30)(A) lawsuits have been filed, raising to over 40 the number of cases filed nationwide as a result of the Ninth Circuit's *Independent Living* decisions. Pet. App. 228; *CAHF v. Maxwell-Jolly*, No. CV10-03259 (C.D. Cal.); *Developmental Servs. Network v. Maxwell-Jolly*, No. CV10-03284 (C.D. Cal.); *Hospital of Barstow, Inc. v. DHCS*, No. 34-2010-80000522 (Cal. Super. Ct. (Sacramento)).

5. The pending administrative proceedings to review California's proposed state plan amendment (SPA) in *California Pharmacists* and *Independent Living IV* further support review. This petition contends,

after all, that private parties should not be able to interject the courts into Medicaid ratemaking before HHS has discharged its duties. The HHS letter to which *California Pharmacists* respondents cite confirms the highly technical and in-depth nature of HHS's review – one that no court has the expertise or resources to replicate. DHCS has not "stalled" the approval process, which is "off the clock" by agreement with the agency, but is actively coordinating its responses with the agency.[10] While respondents have opinions regarding the State's compliance with the Medicaid Act, Congress entrusted oversight of California's $40 billion Medicaid program to HHS, not to respondents.

6. The interlocutory nature of the underlying orders is no impediment given the purely legal nature of the issues and their national importance (as reflected in the 22-state amicus brief filed in *Independent Living*). California and other states should not have to continue to defend against private challenges to their Medicaid programs for another year or longer when the governing legal principles have been announced by the Ninth Circuit. And, Medicaid will incur billions of dollars in unnecessary costs if the Ninth Circuit's wrong precedents remain in effect.

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[10] Although respondents dispute whether a state may implement changes while a SPA is pending, Cal. Pharm. Opp. at 2, the Ninth Circuit did not reach this issue and the authorities respondents cite concern the now-repealed Boren Amendment.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

Respectfully submitted,

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Nos. 09-958, 09-1158, and 10-283

AND
BRIEFS

In the
Supreme Court of the United States

TOBY DOUGLAS, Director of the Department of Health Care Services, State of California,

v.

INDEPENDENT LIVING CENTER OF SOUTHERN CALIFORNIA, INC., A Nonprofit Corporation, et al.

TOBY DOUGLAS, Director of the Department of Health Care Services, State of California, et al.,

v.

CALIFORNIA PHARMACISTS ASSOCIATION, et al.

TOBY DOUGLAS, Director of the Department of Health Care Services, State of California,

v.

SANTA ROSA MEMORIAL HOSPITAL, et al.

On Writs of Certiorari to the United States Court of Appeals for the Ninth Circuit

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5/19/2008	1	NOTICE OF REMOVAL from Superior Court of the State of California for the County of Los Angeles, case number BS114459 with conformed copy of summon and verified petition for writ of mandamus. Case assigned to Judge Christina A. Snyder, Discovery to Magistrate Judge Margaret A Nagle. (Filing fee $350 PAID.), filed by respondents Sandra Shewry, California Department of Health Care Services.(ghap) (Additional attachment(s) added on 5/29/2008: # 1 Exhibits A – E, # 2 Exhibit F) (ds). (Additional attachment(s) added on 5/29/2008: # 3 Notice of Assignment, # 4 Civil Cover Sheet) (ds). (Entered: 05/23/2008)
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		hearing on 6/23/2008 at 10:00 AM before Judge Christina A. Snyder. (Carman, Lynn) (Entered: 05/30/2008)
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6/1/2008	12	NOTICE OF DISMISSAL filed by Petitioner [Independent Living Center of Southern California, et al.,] pursuant to FRCP 41a(1) Without Prejudice as to California Department of Health Care Services. (Carman, Lynn) (Entered: 06/01/2008)
6/2/2008	29	NOTICE OF LODGING filed Proposed Order re MOTION for Preliminary Injunction re: federal preempted 10% Medicaid payment cuts 10 (Attachments: # 1 Exhibit, # 2 Document) (Friedman, Stanley) (Entered: 06/02/2008)
6/12/2008	35	MEMORANDUM in Opposition to MOTION for Preliminary Injunction re: federal preempted 10% Medicaid payment cuts 10 filed by Respondents Sandra Shewry, California Department of Health Care Services. (Attachments: * * *) (Ugaz, Sara) (Entered: 06/12/2008)

6/16/2008	43	REPLY IN SUPPORT OF MOTION for Preliminary Injunction re: federal preempted 10% Medicaid payment cuts 10 FOR 6/23/08 HEARING filed by Petitioners [Independent Living Center of Southern California, et al.]. (Carman, Lynn) (Entered: 06/16/2008)
6/23/2008	46	MINUTES OF Motion Hearing on Petitioner's Motion for Preliminary Injunction 10 held before Judge Christina A. Snyder. The Court takes petitioner's motion under submission. The Court will issue a final order. Court Reporter: Laura Elias. (cj) (Entered: 06/23/2008)
6/25/2008	47	ORDER DENYING PETITIONERS' MOTION FOR A PRELIMINARY INJUNCTION by Judge Christina A. Snyder: The Court hereby DENIES Petitioners' Motion for Preliminary Injunction 10. See document for details. (gk) (Entered: 06/25/2008)
6/26/2008	48	NOTICE OF APPEAL to the 9th CCA filed by Petitioners [Independent Living Center of Southern California, et al.]. Appeal of Order 47 FEE NOT PAID. (Attachments: # 1 Civil Appeals Docketing Statement) (Friedman, Stanley) (Entered: 06/26/2008)
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7/16/2008 66 ORDER from 9th CCA filed re: Notice of Appeal to 9th Circuit Court of Appeals, 48 filed by [Independent Living Center of Southern California, et al.], CCA # 08-56061. Because of the urgency of the district court's conducting the preliminary injunction hearing on the merits, this order directs the clerk to issue the mandate forwith [sic]. We delete from the order, however, the second and third sentences of the final paragraph that relate to the issuance of the stay; the two sentences commence with "We also" and end with "form [sic] this court." The

		panel retains jurisdiction over the stay request and will reconsider the question of a stay [in] light of the motion for reconsideration filed by the appellees. An order as to the stay will issue subsequently. Order received in this district on 7/16/08. (car) (Entered: 07/18/2008)
7/16/2008	68	MANDATE of 9th CCA filed re: Notice of Appeal to 9th Circuit Court of Appeals, 48, CCA # 08-56061. Order denying appellants' motion for a preliminary injunction order is vacated and remand for further proceedings. Mandate received in this district on 7/16/08. (lr) (Entered: 07/22/2008)
7/25/2008	74	MEMORANDUM in Support Preliminary Injunction filed by Petitioners [Independent Living Center of Southern California, et al.]. (Carman, Lynn) (Entered: 07/25/2008)
7/25/2008	82	ORDER GRANTING AARP'S EX PARTE APPLICATION TO FILE AMICUS CURIAE BRIEF by Judge Christina A. Snyder: Ordered that AARP's Application for Amicus Status 80 is GRANTED. The Court grants AARP amicus status. IT IS FURTHER ORDERED that AARP's amicus curiae proposed brief lodged with the Court on 7/24/2008 is deemed filed as of the date of this Order. (gk) (Entered: 07/28/2008)

7/25/2008	83	Amicus Curiae Brief of AARP in Support of Petitioners filed by Amicus AARP. (gk) (Entered: 07/28/2008)
7/30/2008	95	MEMORANDUM in Opposition to Petitioners' Supplemental Motion for Preliminary Injunction filed by Respondent Sandra Shewry. (Snuggs, Carmen) (Entered: 07/30/2008)
7/31/2008	101	REPLY support of motion REQUEST for Preliminary Injunction re: Request for Judicial Notice 73 filed by Petitioners [Independent Living Center of Southern California, et al.], Respondent Sandra Shewry. (Friedman, Stanley) (Entered: 07/31/2008)
8/3/2008	106	NOTICE Voluntary Dismissal, Without Prejudice, of Third Cause of Action and Fourth Cause of Action filed by Petitioners [Independent Living Center of Southern California, et al.]. Pursuant to Federal Rule of Civil Procedure 41(a)(1) (Friedman, Stanley) (Entered: 08/03/2008)
8/18/2008	121	ORDER GRANTING IN PART AND DENYING IN PART PETITIONERS MOTION FOR PRELIMINARY INJUNCTION by Judge Christina A. Snyder. Denying the parties' various motions to strike as moot. 98 73 99 120. (rmo) (Entered: 08/19/2008)
8/26/2008	127	NOTICE OF APPEAL to the 9th CCA filed by Respondent Sandra

		Shewry. Appeal of Preliminary Injunction, Order 121 FEE BILLED. (Ugaz, Sara) Modified on 8/27/2008 (dmap). (Entered: 08/26/2008)
8/27/2008	132	NOTICE OF MOTION AND First MOTION to Alter Judgment re Preliminary Injunction, Order 121. filed by Respondent SANDRA SHEWRY Sandra Shewry. Motion set for hearing on 9/22/2008 at 10:00 AM before Judge Christina A. Snyder. (Attachments: * * *) (Snuggs, Carmen) (Entered: 08/27/2008)
8/27/2008	135	ORDER by Judge Christina A. Snyder, Modifying Preliminary Injunction. 121 132. (rmo) ** ORDER VACATED PURSUANT TO CIVIL MINUTES OF 1/22/2010 323 ** Modified on 1/25/2010 (gk). (Entered: 08/29/2008)
8/29/2008	151	MOTION to Intervene Pursuant to Federal Rule of Civil Procedure 24 and for Leave to File Brief in Opposition to Motion to Alter or Amend filed by Proposed Petitioners in Intervention Sacramento Family Medical Clinics, Inc., Theodore M. Mazer, M.D., Eastern Plumas Health Care District, Pioneers Memorial Health Care Distirct, Kaweah Delta Health Care District, Ronald B. Mead, D.D.S. and Acacia Adult Day Services. Motion set for hearing on 9/22/2008 at 10:00 AM before Judge Christina A. Snyder. (gk) (Entered: 09/09/2008)

8/29/2008	152	MEMORANDUM of Points and Authorities in Support of Motion to Intervene Pursuant to Federal Rule of Civil Procedure 24 151 filed by Proposed Intervenors Sacramento Family Medical Clinics, Inc., Theodore M. Mazer, M.D., Eastern Plumas Health Care District, Pioneers Memorial Health Care District, Kaweah Delta Health Care District, Ronald B. Mead, D.D.S. and Acacia Adult Day Services. (gk) (Entered: 09/09/2008)
9/7/2008	147	Opposition to re: First MOTION to Alter Judgment re Preliminary Injunction, Order 121 .First MOTION to Alter Judgment re Preliminary Injunction, Order 121 . 132 filed by Petitioners [Independent Living Center of Southern California, et al.]. (Attachments: * * *) (Friedman, Stanley) (Entered: 09/07/2008)
9/11/2008	165	REPLY to Petitioners' Opposition to First MOTION to Alter Judgment re Preliminary Injunction, Order 121 .First MOTION to Alter Judgment re Preliminary Injunction, Order 121 . 132 filed by Respondent Sandra Shewry. (Snuggs, Carmen) (Entered: 09/11/2008)
9/15/2008	174	MINUTES OF Motion Hearing held before Judge Christina A. Snyder RE: Proposed Intervenors Motion to Intervene 151: A hearing was held on September 15, 2008. After carefully

considering the arguments set forth by the parties, the Court finds and concludes as follows. The Court GRANTS the motion to intervene as to proposed intervenors Sacramento Family Medical Clinics, Inc.; Theodore M. Mazer, M.D.; Ronald B. Mead, D.D.S.; and Acacia Adult Day Services. The Court DENIES the motion to intervene as to proposed intervenors Eastern Plumas Health Care District, Pioneers Memorial Health Care District, and Kaweah Delta Health Care District. Refer to document for details of the Order. Court Reporter: Laura Elias. (pso) (Entered: 09/17/2008)

9/15/2008 175 MINUTES OF Motion Hearing held before Judge Christina A. Snyder RE: Respondents Motion to Alter or Amend, and Clarify Order Granting in Part Petitioners Motion for Preliminary Injunction 132. The Court denies respondents request to clarify, alter, or amend the order with regard to clinics, as the record does contain evidence of the effect of the ten percent rate reduction for clinics, and the term clinic is not ambiguous. Refer to document for details of the Order. O[bj]ections 166 and 170 finding as moot. Court Reporter: Laura Elias. (pso) (Entered: 09/17/2008)

9/15/2008	177	NOTICE OF PRELIMINARY INJU[NC]TION APPEAL to the 9th CCA filed by petitioners Tran Pharmacy, Inc., Jason Young. Appeal of Order 135, Preliminary Injunction, Order 121 Filed On: 08/18/2008; Entered On: 08/19/2008; Filing fee $455, PAID; RECEIPT NUMBER: 111271. cc: Lynn S. Carman; Edmund G. Brown, Jr. (dmap) (Entered: 09/18/2008)
9/15/2008	180	NOTICE OF PRELIMIN[A]RY INJUNCTION APPEAL to the 9th CCA filed by Petitioners [Independent Living Center of Southern California, et al.]. Appeal of Order 135, Filed On: 8/27/08; Entered On: 8/29/08; Preliminary Injunction, Order 121 Filed On: 8/18/08; Entered On: 8/19/08; Filing fee $455, Paid. receipt number 111270. cc: Lynn S. Carman; Edmund G. Brown, Jr. (lr) (Entered: 09/18/2008)
9/15/2008	368	COMPLAINT IN INTERVENTION against Respondent Sandra Shewry, Director of the Department of Health Care Services of the State of California, filed by Intervenors Sacramento Family Medical Clinics, Inc., Theodore M. Mazer, M.D., Eastern Plumas Health Care District, Pioneers Memorial Health Care District, Kaweah Delta Health Care District, Ronald B. Mead, D.D.S.,

		and Acacia Adult Day Services. (gk) (Entered: 05/25/2010)
9/17/2008	183	ORDER from 9th CCA filed re: Notice of Appeal to 9th Circuit Court of Appeals, 48 filed by [Independent Living Center of Southern California, et al.], CCA # 08-56061. We hereby recall the mandate in this case so that we may file an opinion further describing our order of July 11, 2008, and address any additional petitions for panel rehearing or rehearing en banc. (cbr) (Entered: 09/19/2008)
10/2/2008	191	FIRST AMENDED NOTICE OF APPEAL to 9th CIRCUIT filed by Respondent Sandra Shewry. Amending Notice of Appeal to 9th Circuit Court of Appeals 127 Filed On: 08/26/08; Entered On: 08/26/08; (Kim, Jennifer) (Entered: 10/02/2008)
10/16/2008	200	AMENDED NOTICE OF APPEAL to the 9th CCA [Independent Living Center of Southern California, et al.]. (Friedman, Stanley) Modified on 11/19/2008 (lr). (Entered: 10/16/2008)
10/27/2008	215	NOTICE OF MOTION AND MOTION for Preliminary Injunction re: ENJOIN AB 5 RATE CUT FOR HOME HEALTH SERVICES AND NEMT SERVICES filed by PETITIONERS [Independent Living Center of Southern California, et al.].

Motion set for hearing on 11/17/2008 at 10:00 AM before Judge Christina A. Snyder. (Attachments: * * *) (Carman, Lynn) (Entered: 10/27/2008)

11/3/2008 226 MEMORANDUM in Opposition to MOTION for Preliminary Injunction re: ENJOIN AB 5 RATE CUT FOR HOME HEALTH SERVICES AND NEMT SERVICES 215 filed by Respondent Sandra Shewry. (Attachments: * * *) (Kim, Jennifer) (Entered: 11/03/2008)

11/4/2008 229 NOTICE Petitioners' Notice of Voluntary Dismissal of the Second Cause of Action (Rule 41(a)(1) F.R.C.P.) filed by Petitioners [Independent Living Center of Southern California, et al.]. (Friedman, Stanley) (Entered: 11/04/2008)

11/10/2008 231 REPLY IN SUPPORT MOTION for Preliminary Injunction re: ENJOIN AB 5 RATE CUT FOR HOME HEALTH SERVICES AND NEMT SERVICES 215 filed by Petitioners [Independent Living Center of Southern California, et al.]. (Carman, Lynn) (Entered: 11/10/2008)

11/10/2008 232 REPLY IN SUPPORT MOTION for Preliminary Injunction re: ENJOIN AB 5 RATE CUT FOR HOME HEALTH SERVICES AND NEMT SERVICES 215 filed by Petitioners [Independent Living Center of

Southern California, et al.]. (Carman, Lynn) (Entered: 11/11/2008)

11/17/2008 238 ORDER GRANTING PETITIONERS' THIRD MOTION FOR PRELIMINARY INJUNCTION by Judge Christina A. Snyder: The Court GRANTS Petitioners' Third Motion for Preliminary Injunction 215. The Court hereby orders respondent Director, her agents, servants, employees, attorneys, successors, and all those working in concert with her to refrain from enforcing Cal. Welf. &Inst. Code Section 14105.19(b)(1), including refraining from reducing by ten percent payments under the Medi-Cal fee-for-service program for NEMT and home health services provided on or after 11/17/2008. (gk) (Entered: 11/18/2008)

12/5/2008 242 MANDATE of 9th CCA filed re: Notice of Appeal to 9th Circuit Court of Appeals 48, CCA # 08-56061. The decision of the district court is REVERSED and REMANDED. Mandate received in this district on 12/05/08. (cbr) (Entered: 12/09/2008)

12/16/2008 243 NOTICE OF APPEAL to the 9th CCA filed by Respondent Sandra Shewry. Appeal of Order[,] Preliminary Injunction[,] 238. (Filing Fee NOT PAID.) (Kim, Jennifer) (Entered: 12/16/2008)

2/2/2009	255	MANDATE of 9th CCA filed re: Notice of Appeal to 9th Circuit Court of Appeals, 48, CCA # 08-56061. The Decision of the District Court is REVER[S]ED and REMANDED. Mandate received in this district on 2/02/09. (lr) (Entered: 02/03/2009)
9/15/2009	271	NOTICE OF DISMISSAL filed by PETITIONER Jason Young pursuant to FRCP 41a(1) OF PETITIONER JASON YOUNG ONLY, as to Jason Young, Sandra Shewry. (Carman, Lynn) (Entered: 09/15/2009)
10/29/2009	306	MANDATE of 9th CCA filed re: Notice of Appeal to 9th Circuit Court of Appeals 243, CCA # 08-57016. The decision of the District Court is AFFIRMED. Mandate received in this district on 10/29/09. (cbr) (Entered: 11/02/2009)
12/3/2009	312	MANDATE of 9th CCA filed re: Notice of Appeal to 9th Circuit Court of Appeals, 180, Notice of Appeal to 9th Circuit Court of Appeals 127, CCA # 08-56422, 08-56554. The Decision of the District Court is AFFIRMED in part, REVERSED in part, and REMANDED. Mandate received in this district on 12/03/09. (lr) (Entered: 12/04/2009)
12/21/2009	317	MANDATE of 9th CCA filed re: Notice of Appeal to 9th Circuit Court of Appeals[,] 180, Notice of Appeal to

		9th Circuit Court of Appeals 127, CCA # 08-56422, 08-56554. The Decision of the District Court is AFFIRMED in part, REVERSED in part, and REMANDED. Mandate received in this district on 12/21/09. (lr) (Entered: 12/22/2009)
1/22/2010	323	MINUTES (In Chambers) Order Amending this Court's 8/18/2008 Order Pursuant to the Ninth Circuit Court of Appeals Mandate Issued 12/21/2009 (08-56422 & 08-56554) by Judge Christina A. Snyder: Pursuant to the mandate from the Ninth Circuit, this Court hereby vacates the 8/27/2008 order modifying the injunction 135, and amends the 8/18/2008 order granting in part and denying in part petitioners' motion for preliminary injunction 121 to change the effective date to 7/1/2008. Accordingly, the Court hereby orders respondent Director, her agents, servants, employees, attorneys, successors, and all those working in concert with her to refrain from enforcing Cal. Welf. & Inst. Code Section 14105.19(b)(1), including refraining from reducing by ten percent payments under the Medi-Cal fee-for-service program for physicians, dentists, pharmacies, adult day health care centers, clinics, health systems, and other providers for services provided on or

after 7/1/2008. Court Reporter: N/A. (gk) (Entered: 01/25/2010)

1/29/2010 328 MINUTES (IN CHAMBERS) by Judge Christina A. Snyder: Proceedings: Order Re Respondent's 324 Motion to Alter or Amend and Clarify the 1/22/10 Order, Amending the 8/18/08 Injunction 324. The Court finds this motion appropriate for decision without oral argument. Fed. R. Civ. P. 78; Local Rule 7-15. Accordingly, the hearing date of February 22, 2010, is hereby vacated, and the matter is hereby taken under submission. The Court hereby modifies the third paragraph, set forth at page 2 of its order, as follows: The Court hereby orders respondent Director, her agents, servants, employees, attorneys, successors, and all those working in concert with her to refrain from enforcing Cal. Welf. &Inst. Code § 14105.19(b)(1), including refraining from reducing by ten percent payments under the Medi-Cal fee-for-service program for physicians, dentists, optometrists, prescription drugs, adult day health care centers, and clinics for services provided on or after July 1, 2008. (mg) (Entered: 02/01/2010)

3/26/2010	362	COMPLAINT IN INTERVENTION against Respondent David Maxwell-Jolly filed by Intervenors California Association of Medical Product Suppliers, California Hospital Association, Sharp Memorial Hospital, Grossmont Hospital Corporation, Sharp Chula Vista Medical Center, and Sharp Coronado Hospital and Healthcare Center.(gk) (Entered: 05/13/2010)
5/24/2010	365	ANSWER to Amended Complaint[,] by Respondent to Petitioners' Verified First Amended Petition for Writ of Mandamus filed by Respondent David Maxwell-Jolly. (Snuggs, Carmen) (Entered: 05/24/2010)
6/2/2010	372	RESPONDENT'S ANSWER TO COMPLAINT IN INTERVENTION ANSWER to Intervenor Complaint, 362 filed by Respondent David Maxwell-Jolly. (Snuggs, Carmen) (Entered: 06/02/2010)

Relevant Docket Entries in the United States Court of Appeals for the Ninth Circuit, *Independent Living Center of Southern California v. Maxwell-Jolly*, No. 08-56422

9/4/2008	5	Filed Appellant Sandra Shewry Civil Appeals Docketing Statement. Served on 09/04/2008. (NEW)
9/23/2008	14	Filed order MOATT: (LL) Appeal No. 08-56422, which seeks review of the district court's August 18, 2008 order, was filed August 26, 2008 and is a preliminary injunction appeal. Appeal No. 08-56551, which seeks review of the district court's August 18, 2008 order, was filed September 15, 2008 and is a preliminary injunction appeal. Appeal No. 08-56554, which seeks review of the district court's August 27, 2008 order, was filed September 15, 2008 and is a preliminary injunction appeal. Accordingly, Ninth Circuit Rule 3-3 shall apply to these appeals. * * * Intervenors-Appellees' request for judicial notice filed in appeal No. 08-56422 is construed as a notice of intervenors-appellees' intervenor status in district court. Because the district court granted intervenors-appellees leave to intervene in the district court action, intervenors-appellees are parties here. See NL Industries, Inc. v. Secretary of Interior, 777 F.2d 433, 436

(9th Cir. 1985). Appellant's "emergency motion for an order denying intervening parties permission to file a brief" and petitioners-appellees' request that intervenors-appellees be designated amicus curiae, both filed in appeal No. 08-56422, are denied as moot. Petitioners-Appellees' request that a prior panel hear appeal No. 08-56422 will be addressed by separate order. * * * These appeals shall be calendared together. [08-56422, 08-56551, 08-56554] (DAF)

9/30/2008 16 Filed order (STEPHEN R. REINHARDT, MARSHA S. BERZON and MILAN D. SMITH, JR.) Pursuant to the Court's rules, appeal Nos. 08-56422, 08-56551, and 08-56554 will be heard by the panel that decided appeal No. 08-56061. Petitioners-appellants' motion to consolidate appeal Nos. 08-56422, 08- 56551, and 08-56554 with appeal No. 08-50561 is denied. Petitioners-appellants' motion for injunctive relief and for costs will be addressed by separate order. Petitioners-appellants' motion to assign preliminary injunction appeal Nos. 08-56422, 08-56551, and 08-56554 to the panel that decided the merits of appeal No. 08-56061 is denied as moot. The briefing schedule established previously in preliminary injunction appeals Nos. 08-56422, 08-56551, and

		08-56554 shall remain in effect. [08-56061, 08-56422, 08-56551, 08-56554] (SC)
10/3/2008	17	Received copy of a motion filed in district court re: respondent's amended notice of preliminary injunction appeal. (EL)
10/3/2008	18	Filed Civil Appeals Docketing Statement for aplt Sandra Shewry; Served on 10/01/2008. (DR)
10/14/2008	19	Submitted (ECF) Opening brief for review. Submitted by Appellant Sandra Shewry in 08-56422, Appellee Sandra Shewry in 08-56551, 08-56554. Date of service: 10/14/2008. [6674088] [08-56422, 08-56551, 08-56554] (JMK)
10/14/2008	22	Filed Appellant Sandra Shewry excerpts of record in 14 volumes. Served on 10/14/2008 (WP)
10/15/2008	21	Filed Opening Brief [19] filed by Sandra Shewry. * * * (PK)
10/17/2008	24	Filed (ECF) Appellees [Independent Living Center of Southern California, Inc., et al.] Civil Appeals Docketing Statement (Form 6). Date of service: 10/17/2008. [6678378] (LSC)
10/17/2008	25	Filed original and 15 copies of Appellants [Independent Living Center of Southern California, Inc., et al.] in 08-56554 (Informal: No) opening brief of 10 pages. Served on

		10/15/2008. [08-56554, 08-56422, 08-56551] (FT)
11/12/2008	28	Submitted (ECF) Intervenor brief for review. Submitted by Appellees Acacia Adult Day Services, Theodore Mazer, M.D., Ronald B. Mead and Sacramento Family Medical Clinics, Inc. in 08-56422. Date of service: 11/12/2008. [6705085] [08-56422, 08-56551, 08-56554] (CC)
11/13/2008	31	Submitted (ECF) Answering brief for review. Submitted by Appellees [Independent Living Center of Southern California, Inc., et al.]. Date of service: 11/13/2008. [6706061] (SLF)
11/14/2008	32	Filed Answering Brief [31] filed by [Independent Living Center of Southern California, Inc., et al.] in 08-56422. * * * (WP)
11/17/2008	34	Filed Answering Brief [28] filed by Sacramento Family Medical Clinics, Inc., Theodore Mazer, M.D., Ronald B. Mead and Acacia Adult Day Services. * * * [08-56422, 08-56551, 08-56554] (WP)
11/19/2008	37	Filed AARP and National Senior Citizen's Law Center motion for leave of court to file amici brief in support of Appellee, served on 11/18/08 (WP)

11/19/2008	39	Filed California Optometric Association motion for leave to file amicus brief, served on 11/19/2008 (WP)
11/19/2008	40	Received original and 15 copies of Amicus Curiae California Optometric Association brief in 7 pages. Deficiency: Motion pending. Served on. 11/19/2008 (WP)
11/21/2008	38	Received original and 15 copies of Amici Curiae AARP and National Senior Citizen's Law Center brief in 22 pages. Deficiency: motion pending Served on. 11/18/2008 (WP)
11/26/2008	43	Submitted (ECF) Reply brief for review. Submitted by Intervenors Acacia Adult Day Services, Theodore Mazer, M.D., Ronald B. Mead and Sacramento Family Medical Clinics, Inc. in 08-56554. Date of service: 11/26/2008. [6720921] [08-56554, 08-56422] (JBK)
11/26/2008	44	Filed Reply Brief [43] filed by Sacramento Family Medical Clinics, Inc., Theodore Mazer, M.D., Ronald B. Mead and Acacia Adult Day Services in 08-56554. * * * [08-56422, 08-56551, 08-56554] (LA)
12/2/2008	47	Submitted (ECF) Reply brief for review. Submitted by Appellant Sandra Shewry. Date of service: 12/01/2008. [6724098] (CDS)
12/3/2008	48	ENTRY UPDATED. Filed Intervenor-Appellee Acacia Adult Day Services

		additional citations. Served on 12/02/2008. (fedex to panel) (EL)
12/3/2008	49	Filed Reply Brief [47] filed by Sandra Shewry. * * * (WP)
12/22/2008	59	Filed order (STEPHEN R. REINHARDT, MARSHA S. BERZON and MILAN D. SMITH, JR.) The California Optometric Association's unopposed motion for leave to file an amicus brief is GRANTED. Respondents shall have until January 15, 2009, to file a response to the Association's amicus brief. [08-56422, 08-56551, 08-56554] (BJB)
12/22/2008	60	Filed order (STEPHEN R. REINHARDT, MARSHA S. BERZON and MILAN D. SMITH, JR.) The motion of AARP, the National Senior Citizens' Law Center, and the National Health Law Program for leave to file an amicus brief is GRANTED. Respondents shall have until January 15, 2009, to file a response to the amicus brief. [08-56422, 08-56551, 08-56554] (BJB)
1/15/2009	64	Filed (ECF) Appellant Sandra Shewry response motion (Amicus Motion, Amicus Motion to become amicus). Date of service: 01/15/2009. [6772775] (CDS)
2/18/2009	70	ARGUED AND SUBMITTED TO STEPHEN R. REINHARDT, MARSHA S. BERZON and MILAN D. SMITH,

JR.. [08-56422, 08-57016, 08-56554] (EU)

4/28/2009 75 (ENTRY UPDATED TO ATTACH CORRECT ORDER) Filed clerk order (Deputy Clerk:BJB): Due to a recent change in circumstances, Judge Berzon has recused herself from this case effective today, and Judge W. Fletcher has been drawn to replace her on the panel. [08-56422, 08-57016, 08-56554] (BJB)

5/7/2009 76 Filed (ECF) Appellees [Independent Living Center of Southern California, Inc., et al.] in 08-56422, Appellants [Independent Living Center of Southern California, Inc., et al.] in 08-56554, 08-57016 citation of supplemental authorities. Date of service: 05/07/2009. [6912789] [08-56422, 08-57016, 08-56554] (SLF)

7/9/2009 81 FILED OPINION (STEPHEN R. REINHARDT, WILLIAM A. FLETCHER and MILAN D. SMITH, JR.) The district court properly applied this court's prior decision in Orthopaedic Hospital to hold that Independent Living has demonstrated a likelihood of success on the merits. Moreover, the district court did not abuse its discretion in determining that the balance of hardships tips sharply in Independent Living's favor, as the ten percent rate reduction threatens access

to much-needed medical care. We therefore affirm the district court's order granting in part Independent Living's motion for a preliminary injunction. However, the district court's subsequent order modifying the injunction to apply only to payments for services provided on or after August 18 was based on an erroneous legal standard. The State of California has waived its sovereign immunity against mandamus actions in state courts seeking reimbursement of unlawfully withheld funds, and the Director, by voluntarily removing this case to federal court, waived the State's sovereign immunity in federal court. We therefore reverse the district court's August 18 order modifying the injunction and remand to the district court for further proceedings consistent with this opinion. AFFIRMED in part, REVERSED in part, and REMANDED. Judge: SR, Judge: WAF, Judge: MDS Authoring. FILED AND ENTERED JUDGMENT. [6986365] [08-56422, 08-56554] (PH)

7/23/2009 94 Filed (ECF) Appellant Sandra Shewry petition for panel rehearing and petition for rehearing en banc (from 07/09/2009 opinion). Date of service: 07/23/2009. [7002302] (JMK)

8/17/2009	97	Filed order (MILAN D. SMITH, JR.) Petitioners are directed to file a response to Respondent's Petition for Rehearing En Banc, filed with this court on July 23, 2009. The response shall be filed within 21 days of the date of this order. Per Fed. R. App. P. 32(a)(7)(A), the response shall not exceed fifteen pages in length unless it complies with Fed. R. App. P. 32(a)(7)(B)(ii)-(iii) and (C). [7028875] [08-56422, 08-56554] (BJB)
9/8/2009	98	Filed (ECF) Appellees Acacia Adult Day Services, Mark Beckwith, Margaret Dowling, Gray Panthers of Sacramento, Gray Panthers of San Francisco, Independent Living Center of Southern California, Inc., Theodore Mazer, M.D., Ronald B. Mead, Sacramento Family Medical Clinics, Inc., Jerry Shapiro, Sharon Steen and Jason Young response to Order, Order to set response by any party to anything. Date of service: 09/08/2009. [7055104]. – [COURT spread filing to case 08-56554. 09/09/2009 by MA] (CC)
10/29/2009	101	Filed order (STEPHEN R. REINHARDT, WILLIAM A. FLETCHER and MILAN D. SMITH, JR.) The panel has unanimously voted to deny the petition for rehearing. The full court has been advised of the

		petition for rehearing en banc and no judge of the court has requested a vote on it. Fed. R. App. P. 35. The petition for rehearing en banc is DENIED. [7112659] [08-56422, 08-56554] (BJB)
12/3/2009	106	MANDATE ISSUED. (SR, WAF and MDS) [7150909] [08-56422, 08-56554] (SW)
12/21/2009	112	MANDATE ISSUED. (SR, WAF and MDS) [7170332] [08-56422, 08-56554] (TB)

Relevant Docket Entries in the United States Court of Appeals for the Ninth Circuit, *Independent Living Center of Southern California v. Maxwell-Jolly*, No. 08-56554

9/19/2008	2	Filed Appellants [Independent Living Center of Southern California, Inc., et al.] Civil Appeals Docketing Statement. Served on 09/15/2008. (GR)
9/23/2008	7	Filed order MOATT: (LL) Appeal No. 08-56422, which seeks review of the district court's August 18, 2008 order, was filed August 26, 2008 and is a preliminary injunction appeal. Appeal No. 08-56551, which seeks review of the district court's August 18, 2008 order, was filed September 15, 2008 and is a preliminary injunction appeal. Appeal No. 08-56554, which seeks review of the district court's August 27, 2008 order, was filed September 15, 2008 and is a preliminary injunction appeal. Accordingly, Ninth Circuit Rule 3-3 shall apply to these appeals. * * * Intervenors-Appellees' request for judicial notice filed in appeal No. 08-56422 is construed as a notice of intervenors-appellees' intervenor status in district court. Because the district court granted intervenors-appellees leave to intervene in the district court action, intervenors – appellees are parties

here. See NL Industries, Inc. v. Secretary of Interior, 777 F.2d 433, 436 (9th Cir. 1985). Appellant's "emergency motion for an order denying intervening parties permission to file a brief" and petitioners-appellees' request that intervenors-appellees be designated amicus curiae, both filed in appeal No. 08-56422, are denied as moot. Petitioners-Appellees' request that a prior panel hear appeal No. 08-56422 will be addressed by separate order. * * * These appeals shall be calendared together. [08-56422, 08-56551, 08-56554] (DAF)

9/30/2008 8 Filed order (STEPHEN R. REINHARDT, MARSHA S. BERZON and MILAN D. SMITH, JR.) Pursuant to the Court's rules, appeal Nos. 08-56422, 08-56551, and 08-56554 will be heard by the panel that decided appeal No. 08-56061. Petitioners-appellants' motion to consolidate appeal Nos. 08-56422, 08- 56551, and 08-56554 with appeal No. 08-50561 is denied. Petitioners-appellants' motion for injunctive relief and for costs will be addressed by separate order. Petitioners-appellants' motion to assign preliminary injunction appeal Nos. 08-56422, 08-56551, and 08-56554 to the panel that decided the merits of appeal No. 08-56061 is denied as moot. The briefing

		schedule established previously in preliminary injunction appeals Nos. 08-56422, 08-56551, and 08-56554 shall remain in effect. [08-56061, 08-56422, 08-56551, 08-56554] (SC)
10/15/2008	12	Received original and 15 copies of Appellants [Independent Living Center of Southern California, Inc., et al.] opening brief (Informal: No) 10 pages. Served on 10/15/2008. Deficiency: Motion pending. : (FT)
10/15/2008	13	Received Appellants [Independent Living Center of Southern California, Inc., et al.], Appellee Sandra Shewry and Intervenors Acacia Adult Day Services, Theodore Mazer, M.D., Ronald B. Mead and Sacramento Family Medical Clinics, Inc. Notice regarding Adoption of Excerpts of Record already filed in companion appeals 08-56061 and 08-56422. (FT)
10/17/2008	15	Filed original and 15 copies of Appellants [Independent Living Center of Southern California, Inc., et al.] in 08-56554 (Informal: No) opening brief of 10 pages. Served on 10/15/2008. [08-56554, 08-56422, 08-56551] (FT)
10/30/2008	24	Received copy of amended notice of appeal from district court. (BY)
11/12/2008	18	Submitted (ECF) Answering brief for review. Submitted by Appellee

Sandra Shewry. Date of service: 11/12/2008. [6704959] (CDS)

11/12/2008 19 Submitted (ECF) Intervenor brief for review. Submitted by Appellees Acacia Adult Day Services, Theodore Mazer, M.D., Ronald B. Mead and Sacramento Family Medical Clinics, Inc. in 08-56422. Date of service: 11/12/2008. [6705085] [08-56422, 08-56551, 08-56554] (CC)

11/14/2008 21 Filed Answering Brief [18] filed by Sandra Shewry in 08-56554. * * * (FT)

11/17/2008 23 Filed Answering Brief [19] filed by Sacramento Family Medical Clinics, Inc., Theodore Mazer, M.D., Ronald B. Mead and Acacia Adult Day Services. * * * [08-56422, 08-56551, 08-56554] (WP)

11/26/2008 28 Submitted (ECF) Reply brief for review. Submitted by Appellants [Independent Living Center of Southern California, Inc., et al.]. Date of service: 11/26/2008. [6720620] (SLF)

11/26/2008 29 Submitted (ECF) Reply brief for review. Submitted by Intervenors Acacia Adult Day Services, Theodore Mazer, M.D., Ronald B. Mead and Sacramento Family Medical Clinics, Inc. in 08-56554. Date of service: 11/26/2008. [6720921] [08-56554, 08-56422] (JBK)

11/26/2008	30	Filed Reply Brief [29] filed by Sacramento Family Medical Clinics, Inc., Theodore Mazer, M.D., Ronald B. Mead and Acacia Adult Day Services in 08-56554. * * * [08-56422, 08-56551, 08-56554] (LA)
11/26/2008	31	Filed Reply Brief [28] filed by [Independent Living Center of Southern California, Inc., et al.] in 08-56554. * * * (FT)
2/18/2009	47	ARGUED AND SUBMITTED TO STEPHEN R. REINHARDT, MARSHA S. BERZON and MILAN D. SMITH, JR.. [08-56422, 08-57016, 08-56554] (EU)
4/28/2009	51	(ENTRY UPDATED TO ATTACH CORRECT ORDER) Filed clerk order (Deputy Clerk: BJB): Due to a recent change in circumstances, Judge Berzon has recused herself from this case effective today, and Judge W. Fletcher has been drawn to replace her on the panel. [08-56422, 08-57016, 08-56554] (BJB)
5/7/2009	52	Filed (ECF) Appellees [Independent Living Center of Southern California, Inc., et al.] in 08-56422, Appellants [Independent Living Center of Southern California, Inc., et al.] in 08-56554, 08-57016 citation of supplemental authorities. Date of service: 05/07/2009. [6912789] [08-56422, 08-57016, 08-56554] (SLF)

7/9/2009	57	FILED OPINION (STEPHEN R. REINHARDT, WILLIAM A. FLETCHER and MILAN D. SMITH, JR.) The district court properly applied this court's prior decision in Orthopaedic Hospital to hold that Independent Living has demonstrated a likelihood of success on the merits. Moreover, the district court did not abuse its discretion in determining that the balance of hardships tips sharply in Independent Living's favor, as the ten percent rate reduction threatens access to much-needed medical care. We therefore affirm the district court's order granting in part Independent Living's motion for a preliminary injunction. However, the district court's subsequent order modifying the injunction to apply only to payments for services provided on or after August 18 was based on an erroneous legal standard. The State of California has waived its sovereign immunity against mandamus actions in state courts seeking reimbursement of unlawfully withheld funds, and the Director, by voluntarily removing this case to federal court, waived the State's sovereign immunity in federal court. We therefore reverse the district court's August 18 order modifying the injunction and remand to

		the district court for further proceedings consistent with this opinion. AFFIRMED in part, REVERSED in part, and REMANDED. Judge: SR, Judge: WAF, Judge: MDS Authoring. FILED AND ENTERED JUDGMENT. [6986365] [08-56422, 08-56554] (PH)
8/17/2009	63	Filed order (MILAN D. SMITH, JR.) Petitioners are directed to file a response to Respondent's Petition for Rehearing En Banc, filed with this court on July 23, 2009. The response shall be filed within 21 days of the date of this order. Per Fed. R. App. P. 32(a)(7)(A), the response shall not exceed fifteen pages in length unless it complies with Fed. R. App. P. 32(a)(7)(B)(ii)-(iii) and (C). [7028875] [08-56422, 08-56554] (BJB)
9/8/2009	64	Filed (ECF) Appellees Acacia Adult Day Services, Mark Beckwith, Margaret Dowling, Gray Panthers of Sacramento, Gray Panthers of San Francisco, Independent Living Center of Southern California, Inc., Theodore Mazer, M.D., Ronald B. Mead, Sacramento Family Medical Clinics, Inc., Jerry Shapiro, Sharon Steen and Jason Young response to Order, Order to set response by any party to anything. Date of service: 09/08/2009. [7055104]. – [COURT

		spread filing to case 08-56554. 09/09/2009 by MA] (CC)
10/29/2009	67	Filed order (STEPHEN R REINHARDT, WILLIAM A. FLETCHER and MILAN D. SMITH, JR.) The panel has unanimously voted to deny the petition for rehearing. The full court has been advised of the petition for rehearing en banc and no judge of the court has requested a vote on it. Fed. R. App. P. 35. The petition for rehearing en banc is DENIED. [7112659] [08-56422, 08-56554] (BJB)
12/3/2009	72	MANDATE ISSUED. (SR, WAF and MDS) [7150909] [08-56422, 08-56554] (SW)
12/21/2009	78	MANDATE ISSUED. (SR, WAF and MDS) [7170332] [08-56422, 08-56554] (TB)

Relevant Docket Entries in the United States Court of Appeals for the Ninth Circuit, *Independent Living Center of Southern California v. Maxwell-Jolly*, No. 08-57016

12/17/2008	3	Filed Appellants Department of Health Care Services and Sandra Shewry Civil Appeals Docketing Statement. Served on 12/16/2008. (GR)
1/16/2009	9	Submitted (ECF) Opening brief for review. Submitted by Appellant Sandra Shewry. Date of service: 01/16/2009. [6773973] (CDS)
1/16/2009		Filed Opening Brief [9] filed by Sandra Shewry. * * * (WP)
1/20/2009	11	Filed Appellant Sandra Shewry excerpts of record in 2 volumes. Served on 01/16/2009 (PANEL) (WP)
1/29/2009	13	Submitted (ECF) Answering brief for review. Submitted by Appellees [Independent Living Center of Southern California, Inc., et al.]. Date of service: 01/29/2009. [6790444] (SLF)
1/30/2009		Filed Answering Brief [13] filed by [Independent Living Center of Southern California, Inc., et al.] in 08-57016. * * * (WP)
2/2/2009	14	Submitted (ECF) Reply brief for review. Submitted by Appellant Sandra

		Shewry. Date of service: 02/02/2009. [6793867] (CDS)
2/3/2009		Filed Reply Brief [14] filed by Sandra Shewry. * * * (PANEL)(WP)
2/18/2009	21	ARGUED AND SUBMITTED TO STEPHEN R. REINHARDT, MARSHA S. BERZON and MILAN D. SMITH, JR.. [08-56422, 08-57016, 08-56554] (EU)
4/28/2009	25	(ENTRY UPDATED TO ATTACH CORRECT ORDER) Filed clerk order (Deputy Clerk: BJB): Due to a recent change in circumstances, Judge Berzon has recused herself from this case effective today, and Judge W. Fletcher has been drawn to replace her on the panel. [08-56422, 08-57016, 08-56554] (BJB)
5/7/2009	26	Filed (ECF) Appellees [Independent Living Center of Southern California, Inc., et al.] in 08-56422, Appellants [Independent Living Center of Southern California, Inc., et al.] in 08-56554, 08-57016 citation of supplemental authorities. Date of service: 05/07/2009. [6912789] [08-56422, 08-57016, 08-56554] (SLF)
8/7/2009	30	FILED MEMORANDUM DISPOSITION (STEPHEN R. REINHARDT, WILLIAM A. FLETCHER and MILAN D. SMITH, JR.) AFFIRMED. FILED AND ENTERED JUDGMENT. [7019649] (DD)

8/21/2009	36	Filed (ECF) Appellants Department of Health Care Services and Sandra Shewry petition for rehearing en banc (from 08/07/2009 memorandum). Date of service: 08/21/2009. [7037139] (GDB)
9/23/2009	37	Filed order (STEPHEN R. REINHARDT, WILLIAM A. FLETCHER and MILAN D. SMITH, JR.): The panel has unanimously voted to deny the petition for rehearing en banc. The full court has been advised of the petition for rehearing en banc and no judge of the court has requested a vote on it. The petition for rehearing en banc is DENIED. [7071317] (AF)
10/29/2009	38	MANDATE ISSUED. (SR, WAF and MDS) [7111877] (RR)

Relevant Docket Entries in the United States District Court for the Central District of California, *Independent Living Center of Southern California, Inc. v. Maxwell-Jolly*, No. CV 09-382 CAS (MANx)

Date	No.	Docket Text
1/16/2009	1	COMPLAINT against Defendant David Maxwell-Jolly. (Filing fee $350: FEE PAID.), filed by plaintiffs Sharon Steen, Tran Pharmacy, Inc., Managed Pharmacy Care, Independent Living Center of Southern California, Inc., Gerald Shapiro. (ghap) (Additional attachment(s) added on 1/21/2009: # 1 Notice of Assignment, # 2 Civil Cover Sheet) (ds). (Additional attachment(s) added on 1/21/2009: # 3 Summons) (ds). (Entered: 01/20/2009)
2/2/2009	10	NOTICE OF MOTION AND MOTION for Preliminary Injunction re: [TO] ENJOIN 5% PHARMACY RATE CUT AND PLAINTIFFS' MEMORANDUM IN SUPPORT OF PRELIMINARY INJUNCTION filed by PLAINTIFFS Sharon Steen, Tran Pharmacy, Inc., Independent Living Center of Southern California, Inc., Gerald Shapiro. Motion set for hearing on 2/23/2009 at 10:00 AM before Judge Christina A. Snyder. (Carman, Lynn) (Entered: 02/02/2009)

2/11/2009	24	OPPOSITION DEFENDANTS OPPOSITION TO PLAINTIFFS MOTION FOR PRELIMINARY INJUNCTION re: MOTION for Preliminary Injunction re: [TO] ENJOIN 5% PHARMACY RATE CUT AND PLAINTIFFS' MEMORANDUM IN SUPPORT OF PRELIMINARY INJUNCTION 10 filed by Defendant David Maxwell-Jolly. (Attachments: * * *) (Kim, Jennifer) (Entered: 02/11/2009)
2/13/2009	25	NOTICE NOTICE [sic] OF ERRATA RE: DEFENDANT'S OPPOSITION TO PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION filed by Defendant David Maxwell-Jolly. (Kim, Jennifer) (Entered: 02/13/2009)
2/16/2009	26	REPLY IN SUPPORT OF MOTION FOR PRELIMINARY INJUNCTION MOTION for Preliminary Injunction re: [TO] ENJOIN 5% PHARMACY RATE CUT AND PLAINTIFFS' MEMORANDUM IN SUPPORT OF PRELIMINARY INJUNCTION 10 filed by Plaintiffs Sharon Steen, Tran Pharmacy, Inc., Independent Living Center of Southern California, Inc., Gerald Shapiro. (Attachments: * * *) (Carman, Lynn) (Entered: 02/16/2009)
2/19/2009	28	ANSWER TO COMPLAINT filed by Defendant David Maxwell-Jolly. (Kim, Jennifer) (Entered: 02/19/2009)

2/23/2009	30	NOTICE OF LODGING filed AND LODGING OF ORDER IN SANTA ROSA MEMORIAL HOSPITAL, ET AL v DAVID MAXWELL-JOLLY re Objection/Opposition (Motion related) * * * 24 (Kim, Jennifer) (Entered: 02/23/2009)
2/23/2009	36	MINUTES OF PLAINTIFFS' MOTION FOR PRELIMINARY INJUNCTION (filed 02/02/09) held before Judge Christina A. Snyder: Hearing held and counsel are present. Tentative order provided. The Court confers with counsel and counsel argue. The Court takes plaintiffs' motion under submission. The Court will issue a final ruling. Court Reporter: Laura Elias. (bm) (Entered: 03/02/2009)
2/27/2009	34	ORDER GRANTING PLAINTIFF'S MOTION FOR PRELIMINARY INJUNCTION by Judge Christina A. Snyder: The Court GRANTS Plaintiffs' Motion for Preliminary Injunction 10. The Court hereby orders respondent Director, his agents, servants, employees, attorneys, successors, and all those working in concert with him to refrain from enforcing Cal. Welf. & Inst. Code Section 14105.191(b)(3), as modified by AB 1183 beginning on March 1, 2009, by refraining from reducing by five percent payments to pharmacies

for prescription drugs (including prescription drugs and traditional over-the counter drugs provided by prescription) provided under the Medi-Cal fee-for-service program. (gk) (Entered: 02/27/2009)

3/13/2009 38 NOTICE OF MOTION AND MOTION for Preliminary Injunction re: DEFENDANTS MOTION TO ALTER OR AMEND, AND CLARIFY ORDER GRANTING PLAINTIFFS; MOTION FOR PRELIMINARY INJUNCTION filed by Defendant David Maxwell-Jolly. Motion set for hearing on 4/6/2009 at 10:00 AM before Judge Christina A. Snyder. (Attachments: * * *) (Cardenas, Jesse) (Entered: 03/13/2009)

3/13/2009 40 NOTICE OF MOTION re MOTION for Preliminary Injunction re: DEFENDANTS MOTION TO ALTER OR AMEND, AND CLARIFY ORDER GRANTING PLAINTIFFS; MOTION FOR PRELIMINARY INJUNCTION 38 filed by Defendant David Maxwell-Jolly. Motion set for hearing on 4/6/2009 at 10:00 AM before Judge Christina A. Snyder. (Cardenas, Jesse) (Entered: 03/13/2009)

3/23/2009 42 OPPOSITION TO DEFENDANT'S MOTION TO ALTER OR AMEND, AND CLARIFY FEB. 27, 2009 ORDER filed by Plaintiffs Sharon

Steen, Tran Pharmacy, Inc., Independent Living Center of Southern California, Inc., Gerald Shapiro. (Attachments: * * *) (Carman, Lynn) (Entered: 03/23/2009)

3/30/2009 43 REPLY BRIEF TO PLAINTIFF'S OPPOSITION to MOTION for Preliminary Injunction re: DEFENDANTS MOTION TO ALTER OR AMEND, AND CLARIFY ORDER GRANTING PLAINTIFFS; MOTION FOR PRELIMINARY INJUNCTION 38 filed by Defendant David Maxwell-Jolly. (Cardenas, Jesse) (Entered: 03/30/2009)

4/3/2009 44 MINUTES (IN CHAMBERS) by Judge Christina A. Snyder: The Court DENIES Defendant's Motion to Alter, Amend, or Clarify the Court's 2/27/2009 Order 38. Court Reporter: Not Present. (gk) (Entered: 04/03/2009)

4/30/2009 46 NOTICE OF PRELIMINARY INJUNCTION APPEAL filed by Defendant David Maxwell-Jolly. (Attachments: # 1 US Court of Appeals for the 9th Circuit Civi[l] A[p]peals Docketing Statement) (Kim, Jennifer) (Entered: 04/30/2009)

5/6/2009 47 NOTICE OF APPEAL to the 9th CCA filed by Defendant David Maxwell-Jolly. (Filing Fee PAID.) (Attachments: # 1 NOTICE OF

		ERROR IN AND CORRECTION TO DOCKET, # 2 NOTICE OF PRELIMINARY INJUNCTION APPEAL, # 3 US COURT OF APPEALS FOR THE NINTH CIRCUIT CIVIL APPEALS DOCKETING STATEMENT) (Kim, Jennifer) (Entered: 05/06/2009)
3/25/2010	74	MANDATE of 9th CCA filed re: Notice of Appeal to 9th Circuit Court of Appeals, 47, CCA # 09-55692. The Decision of the District Court is AFFIRMED. Mandate received in this district on 3/25/2010. (lr) (Entered: 03/26/2010)

Relevant Docket Entries in the United States Court of Appeals for the Ninth Circuit, *Independent Living Center of Southern California, Inc. v. Maxwell-Jolly*, No. 09-55692

Date	No.	Docket Text
5/7/2009	3	Filed Appellant David Maxwell-Jolly Civil Appeals Docketing Statement. Served on 04/30/2009. (JN)
6/17/2009	15	Filed Appellant David Maxwell-Jolly four excerpts of record in 4 volumes. Served on 06/16/2009. [6970843] (GLS)
6/19/2009	12	Submitted (ECF) Opening brief for review. Submitted by Appellant David Maxwell-Jolly. Date of service: 06/16/2009. [6963358] (EB)
6/22/2009	13	Filed clerk order: Opening Brief [12] filed by David Maxwell-Jolly. * * * [6963934] (GLS)
7/29/2009	18	Submitted (ECF) Answering brief for review * * *. Submitted by Appellees Independent Living Center of Southern California, Inc., Gerald Shapiro, Sharon Steen and Tran Pharmacy, Inc.. Date of service: 07/29/2009. [7008929] – [COURT attached certificate of service from deleted entry [7007388]. 08/18/2009 by MA] (LSC)
7/29/2009	19	Received Appellees Independent Living Center of Southern California, Inc., Gerald Shapiro, Sharon Steen and Tran Pharmacy, Inc. four

		supplemental excerpt of record on appeal in 1 volume entitled "Volume 5." Deficiency: motion pending. (SHELF). [7013504] (GLS)
8/4/2009	23	Filed clerk order: Answering Brief [18] filed by Independent Living Center of Southern California, Inc., Gerald Shapiro, Sharon Steen and Tran Pharmacy, Inc. * * * [7017106] (GLS)
8/4/2009	24	Filed Appellees Independent Living Center of Southern California, Inc., Gerald Shapiro, Sharon Steen and Tran Pharmacy, Inc. four supplemental excerpts of record on appeal in 1 volume entitled "Volume 5." [7017215] (GLS)
8/18/2009	27	Submitted (ECF) Reply brief for review. Submitted by Appellant David Maxwell-Jolly. Date of service: 08/18/2009. [7032074] (EB)
8/29/2009	28	Filed clerk order: Reply Brief [27] filed by David Maxwell-Jolly. * * * [7032468] (GLS)
1/19/2010	54	ARGUED AND SUBMITTED TO STEPHEN R. REINHARDT, WILLIAM A. FLETCHER and MILAN D. SMITH, JR.. [7198958] (LN)
1/26/2010	55	Filed (ECF) Appellant David Maxwell-Jolly citation of supplemental authorities. Date of service: 01/26/2010. [7207601] (DP)

2/2/2010	56	Filed (ECF) Appellees Independent Living Center of Southern California, Inc., Jerry Shapiro, Sharon Steen and Tran Pharmacy, Inc. Correspondence: INFORMATION REQUESTED BY THE COURT AT ORAL ARGUMENT. Date of service: 02/02/2010 [7217528] (LSC)
2/2/2010	57	Filed (ECF) Appellees Independent Living Center of Southern California, Inc., Jerry Shapiro, Sharon Steen and Tran Pharmacy, Inc. Correspondence: CORRECTION OF CLERICAL ERROR TO SUBSTITUTE THE CORRECT "EXHIBIT B" TO LETTER FILED BY APPEL[L]EES EARLIER THIS DATE OF FEBRUARY 2, 2010. Date of service: 02/02/2010 [7217649] (LSC)
2/8/2010	58	Filed (ECF) Appellant David Maxwell-Jolly citation of supplemental authorities. Date of service: 02/08/2010. [7223037] (DP)
3/3/2010	59	FILED MEMORANDUM DISPOSITION (STEPHEN R. REINHARDT, WILLIAM A. FLETCHER and MILAN D. SMITH, JR.) AFFIRMED. FILED AND ENTERED JUDGMENT. [7250755] (PH)
3/25/2010	60	MANDATE ISSUED. (SR, WAF and MDS) [7278995] (LC)

Relevant Docket Entries in the United States District Court for the Central District of California, *California Pharmacists Association v. Maxwell-Jolly*, No. CV 09-722 CAS (MANx)

Date	No.	Docket Text
1/29/2009	1	COMPLAINT against Defendant David Maxwell-Jolly. (Filing fee $350 PAID.), filed by Plaintiffs [California Pharmacists Association, et al.]. (et) (ds). (Entered: 02/02/2009)
2/11/2009	13	NOTICE OF MOTION AND MOTION for Preliminary Injunction re: Implementation of rate reduction for pharmacies and adult day health care centers filed by Plaintiffs [California Pharmacists Association, et al.]. Motion set for hearing on 3/9/2009 at 10:00 AM before Judge Christina A. Snyder. (Attachments: * * *) (Sze, Felicia) (Entered: 02/11/2009)
2/13/2009	16	NOTICE OF MOTION AND MOTION for Preliminary Injunction re: AB 1183 Rate Reductions for Hospital Services filed by Plaintiffs [California Pharmacists Association, et al.]. Motion set for hearing on 3/9/2009 at 10:00 AM before Judge Christina A. Snyder. (Attachments: * * *) (Bookman, Lloyd) (Entered: 02/13/2009)
2/26/2009	22	MEMORANDUM in Opposition to MOTION for Preliminary Injunction

		re: Implementation of rate reduction for pharmacies and adult day health care centers 13 filed by Defendant David Maxwell-Jolly. (Attachments: * * *) (Kim, Jennifer) (Entered: 02/27/2009)
2/27/2009	23	MEMORANDUM in Opposition to MOTION for Preliminary Injunction re: AB 1183 Rate Reductions for Hospital Services 16 filed by Defendant David Maxwell-Jolly. (Attachments: * * *) (Kim, Jennifer) (Entered: 02/27/2009)
3/4/2009	25	REPLY in support MOTION for Preliminary Injunction re: AB 1183 Rate Reductions for Hospital Services 16 filed by Plaintiffs [California Pharmacists Association, et al.]. (Attachments: * * *) (Keville, Jordan) (Entered: 03/04/2009)
3/4/2009	26	REPLY to Opposition to Motion for Preliminary Injunction filed by Plaintiffs [California Pharmacists Association, et al.]. (Cannizzo, Craig) (Entered: 03/04/2009)
3/4/2009	29	LODGMENT OF STATE AUTHORITIES re MOTION for Preliminary Injunction re: Implementation of rate reduction for pharmacies and adult day health care centers 13 (REPLY TO OPPOSITION) filed by Plaintiffs [California Pharmacists Association,

et al.]. (Cannizzo, Craig) (Entered: 03/04/2009)

3/5/2009 30 ANSWER to Complaint – (Discovery), Complaint – (Discovery), Complaint – (Discovery) 1 filed by Defendant David Maxwell-Jolly. (Murphy, Randall) (Entered: 03/05/2009)

3/5/2009 31 SUPPLEMENT to MOTION for Preliminary Injunction re: AB 1183 Rate Reductions for Hospital Services 16 Lodgment of State Authority in Support of Reply filed by Plaintiffs [California Pharmacists Association, et al.]. (Attachments: * * *) (Keville, Jordan) (Entered: 03/05/2009)

3/9/2009 35 ORDER by Judge Christina A. Snyder GRANTING Plaintiffs' MOTION for Preliminary Injunction as to Adult Day Health Centers 13. The Court GRANTS plaintiffs' motion for preliminary injunction. The Court hereby orders respondent Director, his agents, servants, employees, attorneys, successors, and all those working in concert with him to refrain from enforcing Cal. Welf. & Inst. Code § 14105.191, as modified by AB 1183 beginning on March 9, 2009, by refraining from reducing by five percent payments to ADHCs provided under the Medi-Cal fee-for-service program. (mg) (Entered: 03/10/2009)

3/9/2009	36	ORDER by Judge Christina A. Snyder DENYING Plaintiffs' MOTION for Preliminary Injunction as to Hospitals 16. The Court DENIES plaintiffs' motion for preliminary injunction with regard to AB 1183's reimbursement rate reduction to hospitals, without prejudice to its being renewed after the Ninth Circuit rules on the appeal in Independent Living Center of Southern California, Inc. v. Sandra Shewry, CV-08-3315-CAS. (mg) TT (Entered: 03/10/2009)
3/11/2009	40	NOTICE OF APPEAL to the 9th CCA filed by Plaintiffs [California Pharmacists Association, et al.]. Appeal of Order, 36. (Filing fee $455, receipt number 09730000000005018086.) (Attachments: * * *) (Keville, Jordan) (Entered: 03/11/2009)
3/11/2009	41	FIRST AMENDED NOTICE OF APPEAL to 9th CIRCUIT filed by Plaintiffs California Hospital Association, Sharp Memorial Hospital, Grossmont Hospital Corporation, Sharp Chula Vista Medical Center, Sharp Coronado Hospital and Healthcare Center. Amending Notice of Appeal to 9th Circuit Court of Appeals, 40 Filed On: 3/11/09; Entered On: 3/11/09; (Attachments:

		* * *) (Keville, Jordan) (Entered: 03/11/2009)
4/6/2009	55	ORDER from 9th CCA filed re: Notice of Appeal to 9th Circuit Court of Appeals[,] 40 filed by [California Pharmacists Association, et al.], CCA # 09-55365. The Plaintiffs MOTION FOR STAY PENDING APPEAL IS GRANTED. Order received in this district on 4/06/09. (lr) (Entered: 04/10/2009)
4/7/2009	50	NOTICE OF APPEAL to the 9th CCA filed by Defendant David Maxwell-Jolly. Appeal of Order[,] 35. (Kim, Jennifer) (Entered: 04/07/2009)
5/28/2009	65	ORDER from 9th CCA filed re: Notice of Appeal to 9th Circuit Court of Appeals[,] 40 filed by [California Pharmacists Association, et al.], CCA # 09-55365. We consider the Urgent Motion for Clarification Pursuant to Circuit Rules 27-3(b) and 27-10 filed by Plaintiffs-Appellants California Pharmacists Association, et al. (the Hospital Plaintiffs). The Hospital Plaintiffs filed the instant motion more than fourteen days after the date of our April 6, 2009 Order, in violation of Circuit Rule 27-10(a). Nevertheless, we find that the Hospital Plaintiffs were not, and could not have been, aware of the matter in which the

Director would implement our Order until after the fourteen-day period had passed. Under the circumstances, and pursuant to Circuit Rule 27-10(a), we enlarge the said fourteen-day period, and consider the motion. We resolve the Hospital Plaintiffs' motion and clarify our April 6, 2009 Order as follows: Those sections, or portions of sections, of the California Welfare and Institutions Code added or amended by Assembly Bill 5 that were not purportedly amended or deleted by the text of California Assembly Bill 1183 are not covered by, nor is the implementation thereof stayed by, our April 6, 2009 Order. Order received in this district on 5/28/09. (lr) (Entered: 06/01/2009)

3/25/2010 77 MANDATE of 9th CCA filed re: Notice of Appeal to 9th Circuit Court of Appeals 50, CCA # 09-55532. The decision of the district court is affirmed. Mandate received in this district on 3/25/2010. (dmap) (Entered: 03/26/2010)

3/25/2010 78 MANDATE of 9th CCA filed re: Notice of Appeal to 9th Circuit Court of Appeals 40, CCA # 09-55365. The decision of the district court is affirmed. Mandate received in this district on 3/25/2010. (dmap) (Entered: 03/26/2010)

4/16/2010	81	MINUTES (IN CHAMBERS): Order Vacating this Court's 3/9/2009 Order and Granting Plaintiffs' Motion for Preliminary Injunction Pursuant to the Ninth Circuit Court of Appeals Mandate Issued 3/25/2010 (09-55365) by Judge Christina A. Snyder: Pursuant to the mandate from the Ninth Circuit, this Court hereby vacates the 3/9/2009 order denying plaintiffs' motion for preliminary injunction with regard to AB 1183's reimbursement rate reduction to hospitals 36. Accordingly, the Court hereby grants plaintiffs' Motion for Preliminary Injunction 46 and orders respondent Director, his agents, servants, employees, attorneys, successors, and all those working in concert with him to refrain from enforcing Cal. Welf. & Inst. Code Section 14105.191 and 14166.245, as modified by AB 1183, beginning on April 16, 2010, by refraining from reducing by five percent payments to hospitals for services provided under the Medi-Cal fee-for-service program, which include non-contract inpatient hospital services, outpatient services, Distinct Part Nursing Facilities, and subacute services. Court Reporter: Not Present. (gk) (Entered: 04/16/2010)
6/16/2010	86	ORDER by Judge Christina A. Snyder GRANTING Joint Motion for

Modification of Court's April 16, 2010 Preliminary Injunction Order 84. The Court's April 16 order will be amended to read as follows Pursuant to the mandate from the Ninth Circuit, this Court hereby vacates the March 9, 2009 order denying plaintiffs' motion for a preliminary injunction with regard to AB 1183's reimbursement rate reduction to hospitals. According, the Court hereby grants plaintiffs' motion for preliminary injunction and orders respondent Director, his agents, servants, employees, attorneys, successors, and all those working in concert with him to refrain from enforcing Cal. Welf. & Inst. Code 14105.191 and 14166.245 with respect to services provided under the fee-for-service Medi-Cal program, by refraining. (See attached Order for further information). (jp) (Entered: 06/17/2010)

Relevant Docket Entries in the United States Court of Appeals for the Ninth Circuit, *California Pharmacists Association v. Maxwell-Jolly*, No. 09-55365

Date	No.	Docket Text
3/12/2009	2	Filed Appellants' Civil Appeals Docketing Statement. Served on 03/11/2009. (FB)
3/12/2009	6	Filed (ECF) Appellants California Hospital Association, Grossmont Hospital Corporation, Sharp Chula Vista Medical Center, Sharp Coronado Hospital and Healthcare Center and Sharp Memorial Hospital EMERGENCY Motion for injunction pending appeal. Date of service: 03/12/2009. [6843589] (JBK)
3/19/2009	10	Filed (ECF) Appellee David Maxwell-Jolly response opposing motion (Civil Appeals Docketing Stmnt Forms). Date of service: 03/18/2009. [6852022] (JMK)
3/20/2009	11	Filed (ECF) Appellants California Hospital Association, Grossmont Hospital Corporation, Sharp Chula Vista Medical Center, Sharp Coronado Hospital and Healthcare Center and Sharp Memorial Hospital reply to response (Response to Motion (ECF Filing)). Date of service: 03/20/2009. [6853670] (JBK)

4/6/2009	21	Filed Order for PUBLICATION In light of the showing made by the Hospital Plaintiffs in this case, we grant their motion for an order staying the rate cuts in AB 1183 with respect to the specified hospital services pending their appeal to this court of the district court's order denying the motion for preliminary injunction. MOTION FOR STAY PENDING APPEAL IS GRANTED.(STEPHEN R. REINHARDT, MARSHA S. BERZON and MILAN D. SMITH, JR.) (PH)
4/9/2009	26	Submitted (ECF) Opening brief for review. Submitted by Appellants California Hospital Association, Grossmont Hospital Corporation, Sharp Chula Vista Medical Center, Sharp Coronado Hospital and Healthcare Center and Sharp Memorial Hospital. Date of service: 04/09/2009. [6878244] (JBK)
4/9/2009		Filed clerk order: Opening Brief [26] filed by California Hospital Association, Sharp Memorial Hospital, Grossmont Hospital Corporation, Sharp Chula Vista Medical Center and Sharp Coronado Hospital and Healthcare Center in 09-55365. * * * (LA)
4/9/2009	27	Filed Appellants' excerpts of record in 9 volumes. Served on 04/08/2009 (LA)

4/20/2009	29	Filed (ECF) Appellee David Maxwell-Jolly motion for reconsideration of nondispositive Judge Order of 04/06/2009. Date of service: 04/20/2009. [6889606] (JMK)
5/7/2009	32	Submitted (ECF) Answering brief for review. Submitted by Appellee David Maxwell-Jolly. Date of service: 05/06/2009. [6913545] (JMK)
5/7/2009		Filed clerk order: Answering Brief [32] filed by David Maxwell-Jolly. * * * (LA)
5/7/2009	33	Filed Appellee David Maxwell-Jolly supplemental excerpts of record on appeal in 1 volume. (LA)
5/13/2009	34	Filed (ECF) Appellant California Hospital Association in 09-55365 Urgent Motion for miscellaneous relief [Urgent Motion for Clarification Pursuant to Circuit Rules 27-3(B) and 27-10]. Date of service: 05/13/2009. [6919269] [09-55365, 09-55532] (JBK)
5/21/2009	37	Filed (ECF) Appellant California Hospital Association in 09-55365 reply to response (Motion (ECF Filing), Motion (ECF Filing) motion for miscellaneous relief (to be used only if no other relief applies), Response to Motion (ECF Filing)). Date of service: 05/21/2009. [6929294] [09-55365, 09-55532] (JBK)

5/26/2009	39	Filed order (STEPHEN R. REINHARDT, WILLIAM A. FLETCHER and MILAN D. SMITH, JR.) Plaintiffs-Appellants are directed to file a response to Defendant-Appellee's Petition for Rehearing En Banc, filed with this court on April 20, 2009. The response shall not exceed 15 pages, shall be filed within 21 days of the date of this order, and Plaintiff-Appellant shall provide this court with 50 copies of any such response. (SC)
5/28/2009	44	Filed order (STEPHEN R. REINHARDT, WILLIAM A. FLETCHER and MILAN D. SMITH, JR.) The Hospital Plaintiffs filed the instant motion more than fourteen days after the date of our April 6, 2009 Order, in violation of Circuit Rule 27-10(a). Nevertheless, we find that the Hospital Plaintiffs were not, and could not have been, aware of the manner in which the Director would implement our Order until after the fourteen-day period had passed. Under the circumstances, and pursuant to Circuit Rule 27-10(a), we enlarge the said fourteen-day period, and consider the motion. We resolve the Hospital Plaintiffs' motion and clarify our April 6, 2009 Order as follows: Those sections, or portions of sections, of the California Welfare and Institutions Code added

		or amended by Assembly Bill 5 that were not purportedly amended or deleted by the text of California Assembly Bill 1183 are not covered by, nor is the implementation thereof stayed by, our April 6, 2009 Order. (SC)
6/1/2009	45	Submitted (ECF) Reply brief for review. Submitted by Appellants California Hospital Association, Grossmont Hospital Corporation, Sharp Chula Vista Medical Center, Sharp Coronado Hospital and Healthcare Center and Sharp Memorial Hospital. Date of service: 06/01/2009. [6939979] (JBK)
6/15/2009		Filed clerk order: Reply Brief [45] filed by California Hospital Association, Sharp Memorial Hospital, Grossmont Hospital Corporation, Sharp Chula Vista Medical Center and Sharp Coronado Hospital and Healthcare Center. * * * (LA)
6/16/2009	49	Filed (ECF) Appellants California Hospital Association, Grossmont Hospital Corporation, Sharp Chula Vista Medical Center, Sharp Coronado Hospital and Healthcare Center and Sharp Memorial Hospital response to petition for rehearing en banc. Date of service: 06/16/2009. [6958844]. [Court corrected docket text to reflect filing – 6/26/09 by SS] (JBK)

8/24/2009	51	Filed order (STEPHEN R. REINHARDT, WILLIAM A. FLETCHER and MILAN D. SMITH, JR.) The panel has unanimously voted to deny the petition for rehearing en banc. The full court has been advised of the petition for rehearing en banc and no judge of the court has requested a vote on it. Fed. R. App. P. 35. The petition for rehearing en banc is DENIED. [7037978] (SC)
1/19/2010	63	ARGUED AND SUBMITTED TO STEPHEN R. REINHARDT, WILLIAM A. FLETCHER and MILAN D. SMITH, JR.. [7199044] [09-55365, 09-55532] (LN)
3/3/2010	64	FILED MEMORANDUM DISPOSITION (STEPHEN R. REINHARDT, WILLIAM A. FLETCHER and MILAN D. SMITH, JR.) REVERSED AND REMANDED. FILED AND ENTERED JUDGMENT. [7250739] (PH)
3/25/2010	65	MANDATE ISSUED. (SR, WAF and MDS) [7278452] (GV)

Relevant Docket Entries in the United States Court of Appeals for the Ninth Circuit, *California Pharmacists Association v. Maxwell-Jolly*, No. 09-55532

Date	No.	Docket Text
4/8/2009	3	Filed Appellant David Maxwell-Jolly Civil Appeals Docketing Statement. Served on 04/07/2009. (BG)
5/19/2009	11	Submitted (ECF) Opening brief for review. Submitted by Appellant David Maxwell-Jolly. Date of service: 05/19/2009. [6926567] (GMC)
5/20/2009	13	Filed Appellant David Maxwell-Jolly excerpts of record in 5 volumes. Served on 05/19/2009 (PK)
5/26/2009	15	Filed clerk order: Opening Brief [11] filed by David Maxwell-Jolly. * * * (LA)
6/30/2009	20	Submitted (ECF) Answering brief for review. Submitted by Appellees Acacia Adult Day Services, California Association For Adult Day Services, Charles Gallagher and Fey Garcia. Date of service: 06/30/2009. [6975733] (JBK)
7/2/2009	21	Filed clerk order: Answering Brief [20] filed by Acacia Adult Day Services, California Association For Adult Day Services, Fey Garcia and Charles Gallagher. * * * [6979134] (PK)

7/28/2009	23	Submitted (ECF) Reply brief for review. Submitted by Appellant David Maxwell-Jolly. Date of service: 07/28/2009. [7007163] (GMC)
7/30/2009	24	Filed clerk order: Reply Brief [23] filed by David Maxwell-Jolly. * * * [7010403] (PK)
1/19/2010	36	ARGUED AND SUBMITTED TO STEPHEN R. REINHARDT, WILLIAM A. FLETCHER and MILAN D. SMITH, JR.. [7199044] [09-55365, 09-55532] (LN)
3/3/2010	37	FILED OPINION (STEPHEN R. REINHARDT, WILLIAM A. FLETCHER and MILAN D. SMITH, JR.) AFFIRMED. Judge: MDS Authoring. FILED AND ENTERED JUDGMENT. [7250575] (RP)
3/25/2010	38	MANDATE ISSUED. (SR, WAF and MDS) [7278098] (SW)

Relevant Docket Entries in the United States District Court for the Northern District of California, *Dominguez v. Schwarzenegger*, No. CV 09-2306 CW

Date	No.	Docket Text
5/26/2009	1	COMPLAINT against Arnold Schwarzenegger, John A. Wagner, David Maxwell-Jolly, John Chiang, Fresno County, Fresno County In-Home Supportive Services Public Authority (Filing fee $350, receipt number 34611032471.). Filed by [Lydia Dominguez, et al.]. (Attachments: * * *) (cp, COURT STAFF) (Filed on 5/26/2009) (Entered 5/27/2009)
06/04/2009	5	MOTION for Preliminary Injunction; MEMORANDUM OF POINTS AND AUTHORITIES IN SUPPORT filed by [Lydia Dominguez, et al.] (Leyton, Stacey) (Filed on 6/4/2009) Modified on 6/5/2009 (cp, COURT STAFF). (Entered: 06/04/2009)
6/15/2009	95	Memorandum in Opposition to 5 MOTION for Preliminary Injunction filed by David Maxwell-Jolly, Arnold Schwarzenegger, John A. Wagner. (Carson, Susan) (Filed on 6/15/2009) Modified on 6/16/2009 (kc, COURT STAFF). (Entered: 06/15/2009)
6/19/2009	110	Reply Memorandum re 5 MOTION for Preliminary Injunction filed by [Lydia Dominguez, et al.]. (Leyton,

Stacey) (Filed on 6/19/2009) (Entered: 06/19/2009)

6/22/2009 126 STATEMENT OF RECENT DECISION pursuant to Civil Local Rule 7-3.d filed by [Lydia Dominguez, et al.]. (Attachments: * * *) (Related document(s) 5) (Leyton, Stacey) (Filed on 6/22/2009) (Entered: 06/22/2009)

6/26/2009 130 PRELIMINARY INJUNCTION. Signed by Judge Claudia Wilken on 6/26/09. (cwlc2, COURT STAFF) (Filed on 6/26/2009) (Entered: 06/26/2009)

6/26/2009 131 ORDER by Judge Claudia Wilken granting 5 Motion for Preliminary Injunction (cwlc2, COURT STAFF) (Filed on 6/26/2009) (Entered: 06/26/2009)

6/29/2009 138 NOTICE OF APPEAL as to 130 Preliminary Injunction, 131 Order on Motion for Preliminary Injunction by John Chiang, David Maxwell-Jolly, Arnold Schwarzenegger, John A. Wagner. (cp, COURT STAFF) (Filed on 6/29/2009) (Entered: 06/30/2009)

7/13/2009 171 AMENDED PRELIMINARY INJUNCTION by Judge Claudia Wilken (cwlc3, COURT STAFF) (Filed on 7/13/2009) Modified on 7/14/2009 (cp, COURT STAFF). (Entered: 07/13/2009)

7/13/2009 172 ORDER CLARIFYING INJUNCTION AND DENYING re 144

MOTION FOR CIVIL CONTEMPT SANCTIONS filed by [Lydia Dominguez, et al.] (cwlc3, COURT STAFF) (Filed on 7/13/2009) Modified on 7/14/2009 (cp, COURT STAFF). (Entered: 07/13/2009)

7/23/2009 202 AMENDED NOTICE OF APPEAL as to 171 Order on Motion for Sanctions, 172 Order[,] 130 Preliminary Injunction, 131 Order on Motion for Preliminary Injunction by David Maxwell-Jolly, Arnold Schwarzenegger, John A. Wagner. Appeal Record due by 8/24/2009. (Zwibelman, Michael) (Filed on 7/23/2009) Modified on 7/24/2009 (cp, COURT STAFF). (Entered: 07/23/2009)

7/24/2009 203 ORDER FURTHER CLARIFYING INJUNCTION. Signed by Judge Claudia Wilken on 7/24/09. (scc, COURT STAFF) (Filed on 7/24/2009) (Entered: 07/24/2009)

7/28/2009 205 AMENDED NOTICE OF APPEAL as to 171 Order on Motion for Sanctions, 172 Order[,] 130 Preliminary Injunction, 203 Order, 131 Order on Motion for Preliminary Injunction by David Maxwell-Jolly, Arnold Schwarzenegger, John A. Wagner (SECOND AMENDED NOTICE). Filing fee $455. Appeal Record due by 8/27/2009. (Zwibelman, Michael)

(Filed on 7/28/2009) (Entered: 07/28/2009)

8/13/2009 212 ANSWER to Complaint by John Chiang, David Maxwell-Jolly, Arnold Schwarzenegger, John A. Wagner. (Carson, Susan) (Filed on 8/13/2009) Modified on 8/14/2009 (jlm, COURT STAFF). (Entered: 08/13/2009)

3/3/2010 262 OPINION of USCA as to 138 Notice of Appeal filed by David Maxwell-Jolly, John Chiang, Arnold Schwarzenegger, John A. Wagner, 205 Amended Notice of Appeal, filed by David Maxwell-Jolly, Arnold Schwarzenegger, John A. Wagner, 202 Amended Notice of Appeal, filed by David Maxwell-Jolly, Arnold Schwarzenegger, John A. Wagner (cp, COURT STAFF) (Filed on 3/3/2010) (Entered: 03/03/2010)

3/25/2010 267 MANDATE of USCA; cost is awarded to the appellee in the amount of $316.90 as to 138 Notice of Appeal, 205 Amended Notice of Appeal, 202 Amended Notice of Appeal, filed by David Maxwell-Jolly, Arnold Schwarzenegger, John A. Wagner (cp, COURT STAFF) (Filed on 3/25/2010) (Entered: 03/25/2010)

Relevant Docket Entries in the United States Court of Appeals for the Ninth Circuit, *Dominguez v. Schwarzenegger*, No. 09-16359

Date	No.	Docket Text
7/1/2009	7	Filed Appellants Civil Appeals Docketing Statement. Served on 06/29/2009. [6978769] (JFF)
08/07/2009	31	Submitted (ECF) Opening brief for review. Submitted by Appellants John Chiang, David Maxwell-Jolly, Arnold Schwarzenegger and John A. Wagner. Date of service: 08/07/2009. [7020506] (GDB)
8/12/2009	33	Filed clerk order: Opening Brief [31] filed by John Chiang, Arnold Schwarzenegger, David Maxwell-Jolly and John A. Wagner. * * * [7025298] (GLS)
8/20/2009	49	Filed Appellants John Chiang, David Maxwell-Jolly, Arnold Schwarzenegger and John A. Wagner excerpts of record in 4 volumes. [7150142] (PANEL) (FT)
9/4/2009	37	Filed Appellees Mikesha Martinez, Herbert M. Meyer, Service Employees International Union California State Council, Service Employees International Union Local 521, Service Employees International Union United Health Care Workers West, Service Employees International Union United Long-Term Care

		Workers and Willie Beatrice Sheppard supplemental excerpts of record on appeal in 2 volumes. [7053194] (FT)
9/4/2009	38	Submitted (ECF) Answering brief for review. Submitted by Appellees [Lydia Dominguez, et al.]. Date of service: 09/04/2009. [7053252] – [COURT UPDATE: Changed type of brief. 09/08/2009 by ASW] (SL)
9/4/2009	40	Filed Appellees' supplemental excerpts of record on appeal in 2 volumes. [7053660] (LA)
9/8/2009	39	Filed clerk order: Answering Brief filed by Appellees. * * * [7053642] (LA)
9/18/2009	42	Submitted (ECF) Reply brief for review. Submitted by Appellants John Chiang, David Maxwell-Jolly, Arnold Schwarzenegger and John A. Wagner. Date of service: 09/18/2009. [7067399] (SMC)
9/18/2009	43	Filed clerk order: Reply Brief filed by John Chiang, Arnold Schwarzenegger, David Maxwell-Jolly and John A. Wagner. * * * [7067446] (LA)
1/19/2010	57	ARGUED AND SUBMITTED TO STEPHEN R. REINHARDT, WILLIAM A. FLETCHER and MILAN D. SMITH, JR.. [7199057] (LN)

3/3/2010	60	FILED OPINION (STEPHEN R. REINHARDT, WILLIAM A. FLETCHER and MILAN D. SMITH, JR.) AFFIRMED. Judge: MDS Authoring. FILED AND ENTERED JUDGMENT. [7250565] (RP)
3/24/2010	63	MANDATE ISSUED. (SR, WAF and MDS) Cost awarded to APPELLEE in the amount of $316.90. [7277067] (TB)

Relevant Docket Entries in the United States District Court for the Northern District of California, *Santa Rosa Memorial Hospital v. Maxwell-Jolly*, No. CV 08-5173 SC

Date	No.	Docket Text
11/14/2008	1	COMPLAINT /no process against Sandra Shewry (Filing fee $350, receipt number 34611025556.). Filed by [Santa Rosa Memorial Hospital, et al.]. (ga, COURT STAFF) (Filed on 11/14/2008) (Entered: 11/17/2008)
12/4/2008	7	AMENDED COMPLAINT FOR INJUNCTIVE AND DECLARATORY RELIEF against Sandra Shewry. Filed by [Santa Rosa Memorial Hospital, et al.]. (Johnson, Dean) (Filed on 12/4/2008) (Entered: 12/04/2008)
1/14/2009	11	MOTION for Preliminary Injunction filed by [Santa Rosa Memorial Hospital, et al.]. Motion Hearing set for 2/20/2009 10:00 AM in Courtroom 1, 17th Floor, San Francisco. (Attachments: * * *) (Johnson, Dean) (Filed on 1/14/2009) (Entered: 01/14/2009)
1/22/2009	13	ANSWER to Amended Complaint by Sandra Shewry. (Zwibelman, Michael) (Filed on 1/22/2009) (Entered: 01/22/2009)
1/30/2009	17	Memorandum in Opposition re 11 MOTION for Preliminary Injunction filed by Sandra Shewry.

		(Attachments: * * *) (Zwibelman, Michael) (Filed on 1/30/2009) (Entered: 01/30/2009)
2/6/2009	21	Reply in Support of 11 Preliminary Injunction filed by [Santa Rosa Memorial Hospital, et al.]. (Attachments: * * *) (Johnson, Dean) (Filed on 2/6/2009) Modified on 2/9/2009 (aaa, Court Staff). (Entered: 02/06/2009)
2/23/2009	30	ORDER by Judge Samuel Conti denying Motion for Preliminary Injunction and Staying Case (sclc2, COURT STAFF) (Filed on 2/23/2009) (Entered: 02/23/2009)
3/3/2009	31	NOTICE OF APPEAL as to 30 Order on Motion for Preliminary Injunction on the Pleadings by Anaheim Memorial Medical Center. Filing fee $455.00., Receipt Number 34611029525 (aaa, Court Staff) (Filed on 3/3/2009) (Additional attachment(s) added on 3/13/2009: # 1 USCA NUMBER: 09-15434) (aaa, Court Staff). (Entered: 03/05/2009)
6/2/2009	45	ORDER of USCA: VACATED AND REMANDED; as to 31 Notice of Appeal, filed by Anaheim Memorial Medical Center (aaa, COURT STAFF) (Filed on 6/2/2009) (Entered: 06/02/2009)

6/4/2009	47	ORDER re Supplemental Briefing (sclc2, COURT STAFF) (Filed on 6/4/2009) (Entered: 06/04/2009)
6/12/2009	48	Supplemental Memorandum to Enjoin AB 5; Exhibits 1-5; in Response to 6/4/2009 Court Order filed by [Santa Rosa Memorial Hospital, et al.]. (Johnson, Dean) (Filed on 6/12/2009) Modified on 6/15/2009 (aaa, COURT STAFF). (Entered: 06/12/2009)
6/17/2009	49	RESPONSE to re 47 Order by Sandra Shewry. (Attachments: * * *) (Zwibelman, Michael) (Filed on 6/17/2009) (Entered: 06/17/2009)
6/19/2009	50	Reply to Opposition filed by [Santa Rosa Memorial Hospital, et al.]. (Sorgen, Michael) (Filed on 6/19/2009) (Entered: 06/19/2009)
6/25/2009	52	MANDATE of USCA: The judgment of this Court, entered 6/1/09, takes effect this date. This constitutes the formal mandate of this Court; as to 31 Notice of Appeal, filed by Anaheim Memorial Medical Center (aaa, COURT STAFF) (Filed on 6/25/2009) (Entered: 06/25/2009)
6/26/2009	54	ORDER (sclc2, COURT STAFF) (Filed on 6/26/2009) (Entered: 06/26/2009)
9/9/2009	59	ORDER LIFTING STAY; SETTING NEW BRIEFING SCHEDULE.

Signed by Judge Samuel Conti on 9/9/2009. (sclc2, COURT STAFF) (Filed on 9/9/2009) (Entered: 09/09/2009)

10/12/2009 60 Amended MOTION for Preliminary Injunction; Notice of Motion; Memorandum of Points and Authorities filed by [Santa Rosa Memorial Hospital, et al.]. Motion Hearing set for 11/20/2009 10:00 AM in Courtroom 1, 17th Floor, San Francisco. (Attachments: * * *) (Johnson, Dean) (Filed on 10/12/2009) (Entered: 10/12/2009)

10/30/2009 61 Memorandum in Opposition re 60 Amended MOTION for Preliminary Injunction; Notice of Motion; Memorandum of Points and Authorities filed by Sandra Shewry. (Attachments: * * *) (Zwibelman, Michael) (Filed on 10/30/2009) (Entered: 10/30/2009)

11/6/2009 64 Reply to Opposition re 60 Amended MOTION for Preliminary Injunction; Notice of Motion; Memorandum of Points and Authorities filed by [Santa Rosa Memorial Hospital, et al.]. (Attachments: * * *) (Johnson, Dean) (Filed on 11/6/2009) (Entered: 11/06/2009)

11/12/2009 65 MOTION for Leave to File Surreply in Further Opposition to Amended Preliminary Injunction Motion filed by Sandra Shewry. (Attachments:

		* * *) (Zwibelman, Michael) (Filed on 11/12/2009) (Entered: 11/12/2009)
11/16/2009	66	Reply Memorandum re 65 MOTION for Leave to File Surreply in Further Opposition to Amended Preliminary Injunction Motion filed by [Santa Rosa Memorial Hospital, et al.]. (Attachments: * * *) (Johnson, Dean) (Filed on 11/16/2009) (Entered: 11/16/2009)
11/16/2009	67	ORDER by Judge Samuel Conti granting 65 Motion for Leave to File Surreply in Further Opposition to Amended Preliminary Injunction Motion (tdm, COURT STAFF) (Filed on 11/16/2009) (Entered: 11/16/2009)
11/18/2009	68	ORDER by Judge Samuel Conti granting 60 Motion for Preliminary Injunction (sclc2, COURT STAFF) (Filed on 11/18/2009) (Entered: 11/18/2009)
11/19/2009	71	ORDER STAYING PRELIMINARY INJUNCTION AND CASE. Signed by Judge Samuel Conti on 11/19/2009. (sclc2, COURT STAFF) (Filed on 11/19/2009) (Entered: 11/19/2009)
11/19/2009	72	NOTICE OF APPEAL as to 68 Order on Motion for Preliminary Injunction by Sandra Shewry. Filing fee $455.00. Receipt Number 34611039124 (aaa, COURT STAFF) (Filed on 11/19/2009) (Additional attachment(s) added on

		11/30/2009: # 1 USCA NUMBER: 09-17633) (aaa, COURT STAFF). (Entered: 11/20/2009)
12/2/2009	80	ORDER by Judge Samuel Conti granting 77 Ex Parte Application to Vacate Stay of Preliminary Injunction and Restoring Preliminary Injunction (sclc2, COURT STAFF) (Filed on 12/2/2009) (Entered: 12/02/2009)
12/10/2009	83	ORDER by Judge Samuel Conti denying 81 Motion for Order to Show Cause; Clarifying Preliminary Injunction (sclc2, COURT STAFF) (Filed on 12/10/2009) (Entered: 12/10/2009)
12/16/2009	89	AMENDED NOTICE OF APPEAL as to 68 Order on Motion for Preliminary Injunction, 88 Order, 80 Order on Ex Parte Application, 83 Order on Motion for Order to Show Cause by Sandra Shewry. Filing fee $455. (Zwibelman, Michael) (Filed on 12/16/2009) (Additional attachment(s) added on 9/8/2010: # 1 Petition for Writ of Certi[o]rari: Case Number 10-283) (aaa, COURT STAFF). (Entered: 12/16/2009)
6/4/2010	92	USCA Memorandum: AFFIRMED; as to 89 Amended Notice of Appeal, filed by Sandra Shewry, 72 Notice of Appeal, filed by Sandra Shewry (aaa, COURT STAFF) (Filed on 6/4/2010) (Entered: 06/04/2010)

6/30/2010	93	MANDATE of USCA: The judgment of this Court, entered May 27, 2010, takes effect this date. This constitutes the formal mandate of this Court. FOR THE COURT; as to 89 Amended Notice of Appeal, filed by Sandra Shewry, 72 Notice of Appeal, filed by Sandra Shewry (aaa, COURT STAFF) (Filed on 6/30/2010) (Entered: 06/30/2010)

Relevant Docket Entries in the United States Court of Appeals for the Ninth Circuit, *Santa Rosa Memorial Hospital v. Maxwell-Jolly*, No. 09-17633

11/24/2009	5	Filed Appellant Sandra Shewry Civil Appeals Docketing Statement. Served on 11/19/2009. [7143452] (CW)
12/17/2009	6	Submitted (ECF) Opening brief for review. Submitted by Appellant David Maxwell-Jolly. Date of service: 12/17/2009. [7167504] (MAZ)
12/17/2009	10	Filed Appellant David Maxwell-Jolly excerpts of record in 7 volumes. With Volume 1-A. Served on 12/17/2009. [7168545] (WP)
12/18/2009	9	Filed clerk order: The opening brief [6] submitted by David Maxwell-Jolly is filed. * * * [7168541] (WP)
1/10/2010	13	Submitted (ECF) Answering brief for review. Submitted by Appellees [Santa Rosa Memorial Hospital, et al.]. Date of service: 01/10/2010. [7188837] (DLJ)
1/12/2010	14	Filed clerk order: The answering brief [13] submitted by [Santa Rosa Memorial Hospital, et al.] is filed. * * * [7192521] (PK)
1/25/2010	16	Submitted (ECF) Reply brief for review. Submitted by Appellant David Maxwell-Jolly. Date of service: 01/25/2010. [7207411] (MAZ)

1/27/2010	17	Filed clerk order: The reply brief [16] submitted by David Maxwell-Jolly is filed. * * * [7210407] (PK)
5/12/2010	22	ARGUED AND SUBMITTED TO PROCTER R. HUG, PAMELA ANN RYMER and M. MARGARET MCKEOWN. [7334798] (AN)
5/27/2010	23	FILED MEMORANDUM DISPOSITION (PROCTER R. HUG, PAMELA ANN RYMER and M. MARGARET MCKEOWN) AFFIRMED. FILED AND ENTERED JUDGMENT. [7351898] (DD)
6/18/2010	25	MANDATE ISSUED. (PRH, PAR and MMM) [7377208] (SW)

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IN THE UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF CALIFORNIA
WESTERN DIVISION

INDEPENDENT LIVING CENTER OF SOUTHERN CALIFORNIA, a nonprofit corporation; GRAY PANTHERS OF SACRAMENTO, a nonprofit corporation; GRAY PANTHERS OF SAN FRANCISCO, a nonprofit corporation;	Case No. **CV08-03315** (Los Angeles Superior Court Case No. BS114459) **RESPONDENTS' NOTICE OF REMOVAL OF ACTION UNDER**

GERALD SHAPIRO, Pharm.D. doing business as Uptown Pharmacy and Gift Shoppe; SHARON STEEN, doing business as Central Pharmacy; MARK BECKWITH; and MARGARET DOWLING, TRAN PHARMACY, INC., AND JASON YOUNG, Petitioners, v. **SANDRA SHEWRY, Director of the Department of Health Care Services, State of California; CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES,** Respondents.	**42 U.S.C. § 1441(b)** (Filed May 19, 2008)

TO THE CLERK OF THE ABOVE-ENTITLED COURT:

PLEASE TAKE NOTICE that Respondents Sandra Shewry, Director of the California Department of Health Care Services, and the California Department of Health Care Services, hereby remove to this Court the state court action described below:

1. On April 22, 2008, Petitioners filed a Verified Petition for Writ of Mandamus in the Superior Court of California, in and for the County of Los Angeles,

entitled "Independent Living Center of Southern California, a nonprofit corporation; Gray Panthers of Sacramento, a nonprofit corporation; Gray Panthers of San Francisco, a nonprofit corporation; Gerald Shapiro, Pharm.D. doing business as Uptown Pharmacy and Gift Shoppe; Sharon Steen, doing business as Central Pharmacy; Mark Beckwith; and Margaret Dowling, Petitioners, vs. Sandra Shewry, Director of the Department of Health Care Services, State of California; California Department of Health Care Services, Respondents" as case number BS114459.

2. In their Verified Petition for Writ of Mandamus, Petitioners, who are health care advocates and Medi-Cal providers and recipients, seek to enjoin Respondents from implementing a 10% reduction in Medi-Cal payments to Medi-Cal providers. Petitioners allege that the proposed reduction, which is planned to go into effect on July 1, 2008, violates the Medicaid Act, namely 42 U.S.C. § 1396a subd. (a)(30)(a), the Americans with Disabilities Act of 1990, and the Social Security Act, among other things.

3. Respondents Sandra Shewry, Director of the California Department of Health Care Services, and the California Department of Health Care Services were served with copies of the Verified Petition for Writ of Mandamus on April 22, 2008.

4. On May 12, 2008, Petitioners filed a Verified First Amended Petition for Writ of Mandamus and a Memorandum in Support of Writ of Mandamus, or in the Alternative, For Permanent or Preliminary

Injunction. The Amended Petition added Petitioners Tran Pharmacy, Inc. and Jason Young. Respondents were served on May 12, 2008 with the Verified First Amended Petition for Writ of Mandamus and the Memorandum in Support of Writ of Mandamus, or in the Alternative, For Permanent or Preliminary Injunction. Petitioners again allege that Respondents violated the Medicaid Act, namely 42 U.S.C. § 1396a subd. (a)(30)(a), the Americans with Disabilities Act of 1990, and the Social Security Act, among other things.

5. On or around May 15, 2008, Petitioners filed an Ex Parte Application for Alternative Writ of Mandamus under California Code of Civil Procedure section 1085 to immediately enjoin Respondents from implementing the 10% reduction in Medi-Cal payments to Medi-Cal providers. The hearing on this application is set for May 20, 2008 at 8:30 a.m. at the Los Angeles Superior Court before the Honorable James C. Chalfant in Department 85.

6. Under 28 U.S.C. § 1331, this civil action is within the original jurisdiction of this Court. Respondents may remove this case to this Court under 28 U.S.C. § 1441(b) because Plaintiff alleges that Respondents violated federal laws, namely the Medicaid Act, the Americans with Disabilities Act, and the Social Security Act.

7. Under 28 U.S.C. § 1446(a), attached are true and correct copies of the state-court file in this case, as served on Respondents:

a. Exhibit A: Verified Petition for Writ of Mandamus.

b. Exhibit B: Civil Case Cover Sheet.

c. Exhibit C: Civil Case Cover Sheet Addendum and Statement of Location.

d. Exhibit D: Verified First Amended Petition for Writ of Mandamus.

e. Exhibit E: Petitioners' Memorandum in Support of Writ of Mandamus, or in the Alternative, For Permanent or Preliminary Injunction.

f. Exhibit F: Petitioners' Notice of Ex Parte Application and Ex Parte Application for Alternative Writ of Mandamus Under § 1085 Cal. Code of Civil Procedure with supporting documentation

Dated: May 19, 2008

Respectfully submitted,

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* * *

EXHIBIT – D

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SUPERIOR COURT OF THE STATE OF CALIFORNIA IN AND FOR THE COUNTY OF LOS ANGELES, UNLIMITED JURISDICTION

INDEPENDENT LIVING CENTER OF SOUTHERN CALIFORNIA, a nonprofit corporation; GRAY PANTHERS OF SACRAMENTO, a nonprofit corporation; THE GRAY PANTHERS OF SAN FRANCISCO, a nonprofit corporation; GERALD SHAPIRO, Pharm.D., doing business as Uptown Pharmacy and Gift Shoppe; SHARON STEEN, doing business as Central Pharmacy; MARK BECKWITH; MARGARET DOWLING; TRAN PHARMACY, INC., a corporation, doing business as Tran Pharmacy; and JASON YOUNG,

-vs.-

SANDRA SHEWRY, Director of Department of Health Care Services of the State of California; DEPARTMENT OF HEALTH CARE SERVICES, a department of the State of California; and DOES 1 through 50,.

Respondents. /

No. BS 114459

VERIFIED FIRST AMENDED PETITION FOR WRIT OF MANDAMUS

VERIFIED FIRST AMENDED PETITION FOR WRIT OF MANDAMUS
(§ 1085 Code of Civil Procedure)

TO THE ABOVE-ENTITLED HONORABLE COURT:

The verified first amended petition for writ of mandamus, under § 1085 Code of Civil Procedure, of petitioners Independent Living Center of Southern California, Inc.; Gray Panthers of Sacramento; The Gray Panthers of San Francisco; Gerald Shapiro, Pham.D., [sic] dba Uptown Pharmacy & Gift Shoppe; Sharon Steen, dba Central Pharmacy; Mark Beckwith; Margaret Dowling; Tran Pharmacy, Inc., dba Tran Pharmacy; and Jason Young, respectfully shows:

Jurisdiction and Venue[1]

1. The above-entitled Superior Court has jurisdiction under Article VI, section 10, California Constitution, and § 1085 Code of Civil Procedure ("Code Civ. Proc."). Venue lies under § 401 Code Civ. Proc. which provides that an action may be filed against an officer or agency of the State of California in any county in which the California Attorney General has an office; and under § 393(b) Code Civ. Proc., which provides that an action may be filed in a county in which a public officer has an office.

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[1] Headings and captions are not allegations, and need not be traversed or denied; but, are set forth only to assist the reader.

Parties

2. (a) The petitioner INDEPENDENT LIVING CENTER OF SOUTHERN CALIFORNIA, INC. ("ILCSCal") is a nonprofit California corporation which was duly organized and incorporated in California on July 25, 1977 pursuant to the General Nonprofit Corporation Law of the State of California.

(b) ILCSCal has its principal office and place of business in, and does business in the County of Los Angeles, California.

3. The petitioner GRAY PANTHERS OF SACRAMENTO ("Gray Panthers Sacto") is a California nonprofit public benefit corporation, whose principal office and place of business is, and does business, in the County of Sacramento, California.

4. (a) The petitioner THE GRAY PANTHERS OF SAN FRANCISCO ("Gray Panthers SF") is a nonprofit California corporation which was duly organized and incorporated in California on August 28, 1978, pursuant to the General Nonprofit Corporation Law of the State of California.

(b) GRAY PANTHERS SF has its principal office and place of business in, and does business, in the City and County of San Francisco, California.

5. (a) The petitioner GERALD SHAPIRO, Pharm.D., is a duly licensed registered pharmacist with License No. 24377, who owns and operates a duly licensed retail pharmacy under the fictitious name of Uptown Pharmacy & Gift Shoppe, under

retail pharmacy license No. PHY 41615, in the City of Los Angeles, California.

(b) The petitioner SHAPIRO's pharmacy participates in the Medi-Cal fee-for-service program and also in Medi-Cal managed care plans, under Medi-Cal provider identification No. PHA 416150.

6. (a) The petitioner SHARON STEEN is an individual who is a copartner in a copartnership which owns and operates a licensed retail pharmacy, under the fictitious name Central Pharmacy, under retail pharmacy license No. PHY 38051, in the City of Santa Monica, California.

(b) The petitioner STEEN's pharmacy participates in the Medi-Cal fee-for-service program and also in Medi-Cal managed care plans, under Medi-Cal provider identification No. PHA 380510.

7. The petitioners MARK BECKWITH, MARGARET DOWLING, and JASON YOUNG are individuals who are recipients in the state-federal Medicaid program in California (which is called "Medi-Cal").

8. (a) The Petitioner TRAN PHARMACY, INC. is California corporation which owns and operates a duly licensed retail pharmacy under the fictitious name of Tran Pharmacy, under retail pharmacy license No. PHY 43647, in Garden Grove, California.

(b) The TRAN PHARMACY, INC.'s pharmacy participates in the Medi-Cal fee-for-service program and also in Medi-Cal managed care plans,

under Medi-Cal provider identification No. PHA 436470.

9. (a) The respondent DEPARTMENT OF HEALTH CARE SERVICES ("Department") is a department of the State of California. The Department administers the Medi-Cal program under § 14000 et seq. California Welfare and Institutions ("Welf. & Inst.") Code. The Department has an office in the County of Los Angeles, California.

(b) The respondent SANDRA SHEWRY ("Director"), is the director of the Department. The Director is exclusively empowered by § 14100.1 and 14105 Welf. & Inst. Code to set all policies, rules and regulations in the Medi-Cal program, including all rates payable to Medi-Cal providers. The Director has an office in the County of Los Angeles. The Director SANDRA SHEWRY is sued in her official capacity, only.

(c) Respondents DOES 1 through 50 are persons and officers whose identity is unknown to petitioners, and who are agents, officers, and servants of the State of California, and who have some function, unknown to petitioners at this time, to assist or to carry out the actions of the respondents complained of in this Petition. Petitioners pray leave of the Court to amend this Petition as and when the identity and functions of DOES 1 through 50 become known to the petitioners.

STANDING

Purposes of the Gray Panther petitioners

10. The membership of each of the Gray Panthers Sacto and of the Gray Panthers SF, respectively, is predominantly over the age of 50. A primary function and purpose of the Gray Panthers Sacto, and of the Gray Panthers SF, respectively, is to advocate and advance the health care and the health care rights and civil rights of their members, (1) a number of whom are Medi-Cal recipients in the Medi-Cal fee-for-services program, (2) a number of whom are Medi-Cal recipients in Medi-Cal managed care plans.

Suit as authorized by Green v. Obledo and the common law

11. (a) The petitioners MARK BECKWITH, MARGARET DOWLING, GERALD SHAPIRO, Pharm.D, SHARON STEEN, and JASON YOUNG are each citizens and residents of the State of California. The ILCSCal, the Gray Panthers Sacto, the Gray Panthers SF, and the Tran Pharmacy, Inc., dba Tran Pharmacy, are also each a corporate citizen and resident of the State of California.

(b) Each of the petitioners, mentioned the preceding sub-Paragraph (a) of Paragraph 11, sue on their own behalf In their own interest, respectively, as well as, also, on behalf of the public of the State of California, to procure the performance by the respondent public officials of public duty, as authorized by *Green v. Obledo,* 29 Cal.3d 126 (1981); namely, the

performance of the mandatory ministerial duty (1) to set aside their policy to implement Sections 14 and 15 of Assembly Bill X3 5 (enacted and eff. Feb. 16, 2008, at Chapter 3, Statutes 2007-2008 Third Extraordinary Session), and (2) to refrain from implementing Sections 14 and 15 of Assembly Bill X3 5, including refraining from reducing payments 10% to Medi-Cal doctors, dentists, pharmacies, those acute care hospitals who have no contract with the Department, and, other providers in the Medi-Cal fee-for-service program, and Medi-Cal managed care plans, commencing July 1, 2008; – which aforesaid actions of the respondents are preempted, under the Supremacy Clause, (article VI, U.S. Constitution), in that the aforesaid actions:

> – (1) violate 42 U.S.C. § 1396a(a)(30)(A), (herein, "Sec. 30(A)," including the quality and access clauses of Sec. 30(A).
>
> – (2) violate the federal Americans with Disabilities Act of 1990, ("ADA");

which suit is permitted and authorized by all laws made and provided therefor, the common law, and by *Green v. Obledo* (1981) 29 Cal.3d 126.

Prudential *jus tertii* suits

12. (a) Each of the pharmacy petitioners, (namely, the Uptown Pharmacy, Central Pharmacy, and Tran Pharmacy, (and their owners who are the plaintiffs Gerald Shapiro, Pharm.D., Sharon Steen, and the Tran Pharmacy, Inc.), also sue in a prudential

jus tertii capacity to assert, respectively, the interests of their respective Medi-Cal beneficiary patients, as well as the interests of their patients with disabilities, in the causes of action, claims, Supremacy Clause preemption, and relief which is sued upon and sought in the within case.

(b) The petitioner ILCSCal also sues in a prudential *jus tertii* capacity, in its capacity as an independent living center, – designated and organized as such, and with purposes and powers therefore, under and as authorized by the state Rehabilitation Act, § 19800 et seq. Welf. & Inst. Code, – to assert the interests of its clients who are Medi-Cal beneficiary patients, as well as the interests of its clients with disabilities, in the causes of action, claims, Supremacy Clause preemption, and relief which is sued upon and sought in the within case.

(c) The petitioners Gray Panthers Sacto and Gray Panthers SF also sue in a prudential *jus tertii* capacity, respectively, to assert the interests of their respective members who are Medi-Cal beneficiary patients, as well as the interests of their members clients with disabilities, in the causes of action, claims, Supremacy Clause preemption, and relief which is sued upon and sought in the within case.

13. Each of the respondents Gerald Shapiro and Sharon Steen, and the Tran Pharmacy, Inc., a resident California corporation, also sue on all Causes of Action herein in their capacity as citizen resident taxpayers of the State of California, under the

common law and under § 526a, Code Civ. Proc., – in that each is a taxpayer who has been assessed and paid a state income tax, within 12 months on the filing of this *Verified First Amended Petition for Writ of Mandamus,* to the State of California.

14. Each of the petitioners, – as well as each of the patients, clients, and members in respect to whom the pharmacy plaintiffs, the ILCSCal, and the Gray Panthers petitioners are prudential *jus tertii* representatives, – also has standing inasmuch as each has suffered, will suffer, and is threatened to be caused to suffer, concrete and irreparable injury as shall hereinafter be specified, unless respondents are restrained by a writ of mandamus from implementing the statutes which are preempted, under the Supremacy Clause, by Sec. 30(A), and by the ADA, as set forth hereinafter.

FACTS COMMON TO ALL CLAIMS

15. The petitioner MARK BECKWITH was born on October 5, 1957, in Corry, Pennsylvania. He is a citizen and resident of the State of California who resides at [Home Address Omitted]. He is a paraplegic on account of spinal muscular atrophy, who requires oxygen at all times, who receives medical and pharmacy services under the Medi-Cal program. He is a SSI recipient who receives $870 monthly from SSI. His Medi-Cal identification number is [REDACTED]

16. The petitioner MARGARET DOWLING was born in Sandusky, Ohio, on July 29, 1940. She is a citizen and resident of the State of California who resides at [Home Address Omitted]. She is a paraplegic who receives part of her medical services under the Medi-Cal program. Her Medi-Cal identification number is [REDACTED].

17. The petitioner JASON YOUNG was born in Inglewood, California on July 15, 1962. He is a citizen and resident of the State of California who resides at [Home Address Omitted]. He suffers disabilities of blindness and brain damage and is a Supplemental Security Income (SSI) recipient, with SSI identification number of [Social Security Number Omitted]. He receives assistive services from In-Home Supportive Services and medical and other health services from the Medi-Cal managed care program. His Medi-Cal identification number is [REDACTED]

18. – (a) The ILCSCal is a non-profit corporation located in Van Nuys, Santa Clarita and Lancaster, California. The amended articles of incorporation of ILCSCal state that its primary purposes are to:

> " . . . initiate, sponsor, promote, and carry out plans, policies, and activities that will further the prosperity of and enhance the development of persons with disabilities."

The ILCSCal is a designated center for independent living (CIL). CILs are community-based organizations established under the California Rehabilitation Act (§ 19800 Welf. & Inst. Code) to advocate for and

provide services to enable people with disabilities to achieve independence, including equal access to society and to all activities of society.

– (b) The ILCSCal works on issues of benefits counseling, cross-disability peer modeling/ peer counseling, housing referrals, personal assistants referrals, advocacy, and providing technical assistance, information and referral and emergency services, and assistance in locating medical, pharmacy, and other providers to treat, cure, and alleviate their illness, injury, or condition.

19. The ILCSCal serves over 8,000 individuals with disabilities annually, the majority of whom, (96% or more than 7,500), are categorically linked to Medi-Cal as their primary insurance type, because they are SSI beneficiaries under the Social Security Act; and as such, are not mandated into Medi-Cal managed care, so that most of the clients of ILCSCal who receive SSI are not enrolled in Medi-Cal managed care, and instead receive their Medi-Cal services, including physician, dental, and pharmacy services, from fee-for-service Medi-Cal providers.

– (c) Out of these 7,500 clients with disabilities served annually by ILCSCal, approximately 15%, or 1,200, are eligible for both Medi-Cal and Medicare Part B, and as such:

– (1) receive their physician under Medicare, (*except* for such physician services which are not covered by Medicare, *in which case Medi-Cal pays for the physician service*), and, also receive their

pharmacy services under Medicare Part D, (except for certain "carve out" drug products which are excluded from Medicare Part D and are instead dispensed under the Medi-Cal program); and,

– (2) receive their dental care under Medi-Cal fee-for-service.

LEGISLATIVE HISTORY OF ASSEMBLY BILL X3 5

20. On January 10, 2008, the California Governor proclaimed a State fiscal emergency, sent a proposed 2008-2009 budget bill to the Legislature, and called the Legislature into special session.

21. (a) On February 16, 2008 the Governor signed into law the Special Session Budget Bill, (Assembly Bill X3), and, also, Assembly Bill X3 5 (the Special Session health care trailer bill), and Assembly Bill X3 6 (the Special Session human services trailer bill).

(b) Assembly Bill X3 5, eff. February 16, 2008, was chaptered as Chapter 3, Statutes 2007-2008 Third Extraordinary Session.

Assembly Bill X3 5

22. Section 14 of Assembly Bill X3 5 added §14105.19 Welf. & Inst. Code, which:

– in subds. (a), (b)(1), (b)(2), and (c) – (e) provides that reimbursement shall be cut 10% across-the-board

in Medi-Cal fee-for-service to physicians, dentists, pharmacies, skilled nursing facilities, acute care hospitals (in respect to inpatient hospital services) who have no contract with the Department, and other providers in the Medi-Cal fee-for-service program, for services for dates of service on and after July 1, 2008; and,

– in subd. (b)(3) provides that payments shall be reduced by the actuarial equivalent amount specified in subd. (b) of § 14105.9 Welf. & Inst. Code, (i.e., an amount of 10%), to Medi-Cal managed care plans, which reduction is to be effected pursuant to contract amendments or change orders effective on July 1, 2008.

23. Section 15 of Assembly Bill X3 5 added §14105.245 Welf. & Inst. Code, which provides that amounts paid interim payments to acute care hospitals not under contract with the Department, for amounts paid as interim payments for inpatient hospital services covered by Medi-Cal, shall also be cut 10% across-the-board in Medi-Cal fee-for-service for acute care hospitals who have no contract with the Department for fiscal year 2008-09, (commencing July 1, 2008).

24. § 14105.245 Welf. & Inst. Code, (added by Section 15 of Assembly Bill X3 5 as set forth above), provides:

> "(a) The Legislature finds and declares that the state *faces a fiscal crisis that requires unprecedented measures to be taken to reduce*

General Fund expenditures to avoid reducing vital government services necessary for the protection of the health, safety, and welfare of the citizens of the State of California." (Emphasis supplied.)

25. Finally, Secs. 16 and 17 of Assembly Bill X3 5 provide:

"SEC. 16. This act *addresses the fiscal emergency declared by the Governor* by proclamation on January 10, 2008, pursuant to subdivision (f) of Section 10 of Article IV of the California Constitution.

SEC. 17.... In order to make statutory changes *needed to implement cost containment measures affecting health services at the earliest possible time*, it is necessary that this act take effect immediately." (Emphasis supplied.)

Concrete injury from implementing Secs. 14 and 15 of Assembly Bill X3 5.

26. Each of the Petitioners, as well as:

– all Medi-Cal recipients who receive provider services in the Medi-Cal fee-for-service program,

– all Medi-Cal recipients enrolled in Medi-Cal managed care plans,

– all Medi-Cal providers in the Medi-Cal fee-for-service program who are subject to the aforesaid 10% cut in Medi-Cal payments,

– all Medi-Cal managed care plans, and,

– all Medi-Cal providers in respect to or with whom Medi-Cal managed care plans have contracted with or arranged for covered Medi-Cal managed care services to be furnished by them, (in respect to whom the managed care plans will foreseeably and inevitably pass through the aforesaid 10% cut commencing July 1, 2008),

will, respectively, and foreseeably and inevitably, suffer concrete injury, and are threatened with concrete injury, and are put at risk of concrete injury, by the aforesaid 10% cut, or the actuarial equivalent thereof, which will be put into effect commencing July 1, 2008 by the respondents, pursuant to their policy to implement the aforesaid Sections 14, and 15 of Assembly Bill X3 5, including, without limitation thereby, (1) the 10% across-the-board reduction in reimbursement to physicians, dentists, pharmacies, acute-care hospitals who have no contract with the Department, and other providers in the Medi-Cal fee-for-service program; and (2) the equivalent actuarial 10% reduction in payments to Medi-Cal managed care plans, commencing July 1, 2008; (hereinafter referred to, collectively, as "the Medi-Cal cuts"); which concrete injury from the Medi-Cal cuts is great, immediate, and irreparable.

Denial of access to physicians, and denial of quality medical services

27. More particularly, it is a fact that Medi-Cal rates for physicians are 61% or less of what Medicare pays for the same physician services; that a 10% cut will reduce reimbursement to Medi-Cal physicians to only 57% of what Medicare would pay; and that as a result of the low Medi-Cal rates, only 55% of primary care physicians and less than 50% or [sic] specialists are willing to participate in the Medi-Cal program, (either in the Medi-Cal fee-for-service program, or in Medi-Cal managed care programs). (1) These facts are verified and reported by the Legislative Analyst in *Analysis of the 2008-2009 Budget Bill,* (Budget Analysis"), citing studies on the subject, at pages C-37 and C-38 of the Budget Analysis; and (2) studies funded by the California Healthcare Foundation, (a respected organization with whom the Department often contracts to provide studies and information to the Department), consistently so report.

28. Further:

– **First.** It is a fact that persons with disabilities such as the petitioners DOWLING, BECKWITH, and YOUNG, and the thousands of disabled clients of the petitioner ILCSCal, and the thousands of home shut-ins to whom petitioner SHAPIRO and STEEN deliver prescriptions in the Medi-Cal fee-for-service program, have more difficulty in locating primary care and specialists who are needed by them to adequately follow and care for their complex medical needs, and

keep them alive, than do Medi-Cal recipients without disabilities.

– **Second.** It is a fact that although Medi-Cal managed care plans do assign a Medi-Cal enrollee to a primary care physician, nevertheless, persons with severe disabilities such as the petitioners DOWLING, BECKWITH, and YOUNG require more complex care, from specialists, than Medi-Cal managed care plans are able to furnish them, due to a shortage of specialists in both Medi-Cal fee-for-service and Medi-Cal managed care.

– **But,** specialists who have the capability to treat and follow the complex needs of disabled persons, – such as the paraplegic DOWLING, the quadriplegic BECKWITH, and the blind and brain damaged YOUNG, – are difficult to find and retain over any period of time, **whether the specialist is being sought** by disabled Medi-Cal recipients in the Medi-Cal fee-for-service program, or by disabled Medi-Cal recipients in Medi-Cal managed care plans.

– This above situation, set forth in this Paragraph, is due to the fact that payment of specialists is so low that **less than 50% of specialists** have Medi-Cal patients; and, those that do, repeatedly state in surveys that they are **not willing to accept new** Medi-Cal patients, (whether they come from the Medi-Cal fee-for-service program or from Medi-Cal managed care plans).

– However, given the facts which are set forth above in this Paragraph, it is inevitable that, if the

Medi-Cal cuts of Sections 14 and 15 of Assembly Bill X3 5 are implemented for dates of service on and after July 1, 2008, that thousands of Medi-Cal recipients in both Medi-Cal fee-for-service and Medi-Cal managed care, – including (1) the petitioners DOWLING, BECKWITH, and YOUNG; (2) the thousands of disabled patients of the petitioner pharmacies (Uptown, Central, and Tran), in Los Angeles and Orange counties, (3) the thousands of disabled clients of the petitioner ILCSCal, and (4) the members of the Sacto Gray Panthers and the SF Gray Panthers who are Medi-Cal recipients, **will be driven,** and will at the least be put at great risk, of being forced into institutions in order to survive, if at all.

Denial of access to dentists, and to quality dental care

29. It is also a fact, which is reflected in court decisions and studies, that because of too-low rates, approximately 90% of dentists refuse to accept Medi-Cal patients. Accordingly, the 10% reduction in Medi-Cal payments to dentists, will simply intensify the denial of access and quality dentistry, which already presently exists.

Denial of access to pharmacy care

30. California pharmacies, both chain pharmacies and independent pharmacies, uniformly earn less than a 10% net profit.

31. Further, it is fact, – as demonstrated by the 2006 survey by Myers & Stauffer of California pharmacy costs to operate, and their costs to acquire prescription drug products, that approximately 27.5% of a typical pharmacy's prescriptions in the Medi-Cal program are single source (brand) drugs; that approximately 36% of the prescriptions are multi-source (generic) drugs; and that approximately 36.2% of the prescriptions are low-priced drugs in respect to which the federal government has set a federal upper limit ("FUL") or Medi-Cal has set a maximum allowable ingredient cost ("MAIC") limit for reimbursing the pharmacy's cost to acquire such FUL or MAIC.

32. However, the figures set forth in this Myers & Stauffer report to the Department are consistent with the fact, – when the 10% payment cut commences July 1, 2008, – that although California pharmacies including the petitioner pharmacies. would still have a **small net profit** on the 36% of their Medi-Cal prescriptions which are multi-source (generic) prescriptions without a Ful [sic] or MAIC cap, nevertheless, they would have a **larger net loss, collectively,** on the 27.5% of their Medi-Cal prescriptions which are single source (brand) and the 36.2% of their Medi-Cal prescriptions which are subject to a FUL or a MAIC cap; so that on the whole that California pharmacies, including the petitioner pharmacies, will not be able to dispense Medi-Cal prescriptions in the Medi-Cal fee-for-service program except at a net loss on the entire bulk of their Medi-Cal prescription business, (brand, generic, and capped prescriptions).

33. Further, Medi-Cal managed care programs, (such as the Medi-Cal county organized health system managed care program in Orange County which is known as "CalOptima"), typically, (including CalOptima) pass through all reductions in payments by Medi-Cal to Medi-Cal managed care plans; so that (1) pharmacies in Medi-Cal managed care plans, including the petitioner pharmacies, and their patients, will suffer the same reduction in ability to furnish or receive quality pharmacy care, and (2) specialists will become even more scare in managed care plans, so that the frail, elderly, disabled Medi-Cal patients in both the Medi-Cal fee-for-service program, and in Medi-Cal managed care plans, will suffer inability, and be put at risk of inability to obtain specialists, and to obtain quality pharmacy services, if the July 1, 2008 10% cut in payment to Medi-Cal managed care plans is not enjoined by the Court.

34. Accordingly, it is manifest, foreseeable and probable, from the foregoing facts set forth above in this Petition, that the 10% reduction in total reimbursement to pharmacies in the Medi-Cal fee-for-service program, (as well as an actuarially equivalent 10% reduction to Medi-Cal managed care plans), will result in not only many, but most independent pharmacies, such as the petitioners GERALD SHAPIRO, Pharm.D., (owner of Uptown Pharmacy in Los Angeles), and SHARON STEEN, (owner of the independent Central Pharmacy in Santa Monica), and the TRAN PHARMACY, either (1) going out of business, or (2) refusing to accept Medi-Cal any longer, or (3) refusing

to fill those particular Medi-Cal prescriptions in respect to which they suffer a net loss in the acquisition and costs to dispense, or (4) reducing staff, hours of pharmacy operation, and eliminating or reducing delivery services to shut-ins, under the new 10% Medi-Cal payment reduction.

35. Further, many independent pharmacies, but few chain pharmacies, deliver Medi-Cal prescriptions to the aged, frail, and disabled Medi-Cal recipients who are shut-in to their homes.

36. For example, 98% of the prescriptions dispensed by the independent Uptown Pharmacy in Los Angeles, – owned by the petitioner GERALD SHAPIRO, Pharm.D., – are deliveries to approximately 5,000 home shut-ins.

37. More particularly, approximately 55% of the shut-ins to whom Uptown Pharmacy delivers prescriptions receive their medications under Medicare Part D, (i.e., those who are 65 or older, or are Social Security Disability Income beneficiaries). But, also, approximately 30% of the shut-in clientele of Uptown Pharmacy are on the Medi-Cal fee-for-service program, due to the fact they are under 65 or, although disabled, have not qualified for S.S.D.I.

38. However, Uptown's net profit on its entire pharmacy business is less than 10% net profit. Accordingly, the petitioner SHAPIRO, – and two other delivery pharmacies whose owners he knows in Los Angeles, – have no realistic choice but to close their pharmacies if the 10% cut in pharmacy reimbursement

is implemented in July 2008; or at the best, eliminate or reduce deliveries. Thus, if the 10% cut is not restrained by the Court, **thousands of disabled home shut-ins** in Los Angeles, (and similar in other parts of the state), who are Medi-Cal recipients, will no longer have **any access** to life-necessary drugs, and, many of them will suffer and die therefrom.

Summary of overall effect of the 10% Medi-Cal cut

39. Accordingly, due to the too-low rates already paid physicians, dentists, pharmacies, and other providers by Medi-Cal, (1) the further 10% payments reduction if implemented in July 2008, to physicians, will drive and tend to drive even more primary care physicians and specialists, and dentists, pharmacies, and other providers out of the Medi-Cal program, or cause them to terminate present provider-patient relationships, or reduce services, or refuse to [sic] new Medi-Cal patients, or increase appointment wait periods; such that (2) many Medi-Cal recipients, both in the Medi-Cal fee-for-service program and in the Medi-Cal managed care program, – and, especially the tens of thousands who are home-bound shut-ins who depend upon medicine delivery, and also those who are disabled, – will be denied access to life-sustaining medical, dental, and prescription services, with (3) the consequence that Medi-Cal recipients in general will be denied quality medical services and access to quality medical services. More particularly, due to the 10% provider payment cuts (including the

actuarial equivalent thereof to Medi-Cal managed care plans, many **disabled Medi-Cal recipients** such as the petitioners DOWLING, BECKWITH, and YOUNG, and the thousands of clients of independent living centers such as the petitioner ILCSCal, will lose, or are threatened with loss, of their primary care and specialist physicians, so that many persons with disabilities, including the petitioners Beckwith and Dowling, will be forced into institutions or will be at risk of being forced into institutions in order to survive, and will suffer injury and pain from untreated illness, injury, or condition.

FIRST CAUSE OF ACTION

By each of the petitioners except petitioner Jason Young, for mandamus and injunctive relief to enjoin each of the respondents to refrain from implementing a 10% reduction of payments to Medi-Cal fee-for-service providers under subds. (a), (b)(1), (b)(2), and (c) – (e) of § 14105.19 Welf. & Inst. Code, and § 14166.245 Welf. & Inst. Code), – which state statutes and the state action of respondents to implement the state statutes violate, and are hence preempted under the Supremacy Clause by, the quality and equal access clauses of 42 U.S.C. § 1396a(a)(30(A).

* * *

40. Petitioners refer to and incorporate each of the allegations in each of the preceding Paragraphs of this Petition, as if fully set forth herein.

41. The Medicaid Act, in 42 U.S.C. § 1396a, subd. (a)(30)(A), provides:

> "(a) A State plan for medical assistance **must** – (30)(A) **provide for** such methods and procedures relating to the utilization of, and **the payment for, care and services available under the plan** (including but not limited to utilization review plans as provided for in section 1396b(i)(4) of this title) **as may be necessary** to safeguard against unnecessary utilization of such care and services and **to assure that payments are consistent with** efficiency, economy, and **quality of care** and are **sufficient to enlist enough providers** so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area; . . . " (Emphasis supplied.)

[42 and 43 omitted in original.]

44. 42 U.S.C. § 1396a, subd. (a)(30)(A), shall hereinafter be referred to as "Sec. 30(A)."

45. However, in view of the fact that on January 10, 2008, the Governor proclaimed a fiscal emergency and called the Legislature into Special Session; and that on February 16, 2008 the Legislature enacted and the Governor signed into law Assembly Bill X3 5, which proclaims in Sec. 15 that "the state faces a fiscal crisis that requires unprecedented measures to be taken to reduce General Fund expenditures," and which proclaims in Sections 16 and 17 that:

> "SEC. 16. This act *addresses the fiscal emergency declared by the Governor* by proclamation on January 10, 2008, pursuant to subdivision (f) of Section 10 of Article IV of the California Constitution.
>
> SEC. 17 . . . In order to make statutory changes *needed to implement cost containment measures affecting health services, at the earliest possible time,* it is necessary that this act take effect immediately." (Emphasis supplied.)

it is manifest that the sole function and purpose, and the conclusive consideration in the Legislature's decision to enact subds. (a), (b)(1), (b)(2), and (c)-(e) of § 14105.19 Welf. & Inst. Code; and § 14166.245 Welf. & Inst. Code, – which provides that the respondents shall (1) cut Medi-Cal payments to providers in the Medi-Cal fee-for-service program, was budgetary considerations, to "address the fiscal emergency" declared by the Governor, and to effect "cost containment measures affecting health services," by making statutory changes needed to reduce expenditures, (to fit the State's reduced budget), commencing July 1, 2008.

46. However, therein, by each and all of the above allegations, the enactment of subds. (a), (b)(1), (b)(2), and (c)-(e) of § 14105.19 Welf. & Inst. Code; and § 14166.245 Welf. & Inst. Code, by the Legislature (1) was without any consideration of quality and access

as required by Sec. 30(A),[2] and as without any consideration of what it costs providers to perform the various services and procedures, as required by Sec. 30(A);[3] such that the State's sole purpose, and the conclusive factor, in enacting the across-the-board 10% reduction in reimbursement to providers in the Medi-Cal fee-for-service program, was to **reduce the budget deficit**. Accordingly, under the standard of *Orthopaedic Hosp.,* 103 F.3d 1491, at 1500 (1997); and *Arkansas Medical Society, Inc. v. Reynolds,* 6 F.3d 519 (8th Cir.1983), the action of the Legislature to enact the aforesaid subds. (a), (b)(1), (b)(2), and (c)-(e) of § 14105.19 Welf. & Inst. Code; and § 14166.245 Welf. & Inst. Code, and the policy and action of the respondents to implement these statutes by reducing payments to providers in the Medi-Cal fee-for-service program, was and is arbitrary and capricious, and contrary to and in violation of the quality and access provisions of Sec. 30(A); so that hence, under the Supremacy Clause, the aforesaid subds. (a), (b)(1), (b)(2), and (c)-(e) of §14105.19 Welf. & Inst. Code; and § 14166.245 Welf. & Inst. Code are preempted by Sec. 30(A)..

47. Accordingly, by each, and all of the foregoing facts alleged, subds. (a), (b)(1), (b)(2), and (c)-(e) of § 14105.19 Welf. & Inst. Code; and § 14166.245 Welf.

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[2] *Othopaedic* [sic] *Hospital v. Belshe,* 103 F.3d 1491, 1500 (9th Cir.1997).

[3] *Id.,* 103 F.3d at 1500; *Arkansas Medical Society, Inc. v. Reynolds,* 6 F.3d 519 (8th Cir. 1993).

& Inst. Code., were and are unlawful, in violation of the quality and access provisions of Sec. 30(A), so as to be *preempted, under the Supremacy Clause, by the quality and access provisions* of Sec. 30(A), such that the respondent Director and the respondent Department act in excess of and without jurisdiction to implement subds. (a), (b)(1), (b)(2), and (c)-(e) of § 14105.19 Welf. & Inst. Code; and § 14166.245 Welf. & Inst. Code, in implementing the provisions therein of reducing reimbursement to physicians, dentists, pharmacies, and other providers, in the Medi-Cal fee-for-service program, commencing July 1, 2008.

48. Further, unless restrained by the Court by an appropriate writ of mandamus under § 1085 Code Civ. Proc. or by an appropriate injunction, the respondents Director and Department will implement the aforesaid subds. (a), (b)(1), (b)(2), and (c)-(e) of § 14105.19 Welf. & Inst. Code; and § 14166.245 Welf. & Inst. Code, and thereby will cause injury to each of the petitioners (except petitioner Jason Young, who is in a Medi-Cal managed care plan); which injury is irreparable, all, as has been hereinbefore set forth in detail in the within amended Petition, but, the petitioners have no administrative remedy, and the petitioners have no plain, speedy, or adequate remedy whatsoever or at all, except by this Verified First Amended Petition for Writ of Mandamus.

WHEREFORE, the Petitioners respectively pray for judgment as shall hereinafter be specified:

SECOND CAUSE OF ACTION

By petitioners Jason Young and the Tran Pharmacy, Inc., dba Tran Pharmacy, for mandamus and injunctive relief to enjoin each of the respondents to refrain from implementing the actuarial equivalent' of a 10% reduction of payments to Medi-Cal managed care plans under subd. (b)(3) of § 14105.19 Welf. & Inst. Code, which state statute and the action of respondents to implement the state statutes violate, and are hence preempted under the Supremacy Clause by, the quality and equal access clauses of 42 U.S.C. § 1396a(a)(30(A).

* * *

49. Petitioners refer to and incorporate each of the allegations in each of the preceding Paragraphs of this Petition, as if fully set forth herein; and, especially, refer to and incorporate each of the allegations in the First Cause of Action as if fully set forth herein.

50. The provisions of 42 U.S.C. § 1396a(a)(30)(A), – herein, "Sec. 30(A)" – apply to all managed care plans and managed care entities, who arrange to furnish or otherwise furnish Medi-Cal services to their members or beneficiaries, just as directly, fully, and equally as Sec. 30(A) applies to providers in the Medi-Cal fee-for-service program.

51. The provisions of Social Security Act § 1915(b)(4), (42 U.S.C. § 1396n(b)(4)), also specifically, by its terms, requires that the State of California set rates and payments for Medi-Cal managed care plans

and Medi-Cal managed care entities, upon the same standards as are set forth in Sec. 30(A).

52. Accordingly, – by each and all of the allegations in the preceding Paragraphs of this Petition, – and because Medi-Cal managed care plans and entities are agents of the State who, in effect, set the rates which shall be payable to providers for services to Medi-Cal recipients in Medi-Cal managed care plans, – the actions of the Legislature in enacting subd. (b)(3) of § 14105.19 Welf. & Inst. Code, to reduce payments to Medi-Cal managed care plans and entities by 10%, or the actuarial equivalent thereof, was arbitrary and capricious, and contrary to Sec. 30(A), and contrary to Social Security Act § 1915(b)(4), (42 U.S.C. § 1396n(b)(4); such that the policy of the respondents to implement, and the action of the respondents to implement subd. (b)(3) of § 14105.19 Welf. & Inst. Code, including the reduction of payments to Medi-Cal managed care plans and entities by 10%, or the actuarial equivalent thereof, managed care plans and entities, is thereby, under the Supremacy Clause, preempted by Sec. 30(A) and by Social Security Act § 1915(b)(4), (42 U.S.C. § 1396n(b)(4)), such that, unless the Court issues an appropriate writ of mandamus or injunction, the petitioner Jason Young and the petitioner Tran Pharmacy, Inc., dba Tran Pharmacy, (who are a managed care recipient and managed care provider), – will be irreparably injured, and put at risk of injury, in the same wise as has been prior alleged in the First Cause of Action, by the respondents reducing

payments, commencing July 1, 2008, to Medi-Cal managed care plans, in the actuarial equivalent of a 10% reduction in payment, which reduction will be passed through to providers who serve Medi-Cal managed care plan patients, causing fewer providers to participate in Medi-Cal managed care plans and injuring Medi-Cal managed care patients such as petitioner Josh Young, and forcing them or tending to force into institutions in order to survive..

WHEREFORE, the petitioners pray for judgment as shall hereinafter be specified:

THIRD CAUSE OF ACTION

(By all petitioners against each respondent.)

Preemption by the Americans with Disabilities Act of 1990, 42 U.S.C. § 12132, ("ADA"), under the Supremacy Clause, of Sections 14, and 15 of Assembly Bill X3 5, for violation of the ADA, 42 U.S.C. § 12132, by forcing or threatening to force disabled persons into institutions, – such that such administration of the Medi-Cal program prevents, and does not provide, disabled persons with the most integrated setting appropriate to their needs, as mandated by the ADA and by *Olmstead v. L.C., 527 U.S. 581 (1999).*

53. Petitioners here refer to and incorporate each of the allegations in the preceding Paragraphs as if fully set forth herein.

54. By each and all of the foregoing facts alleged in Paragraphs 1 through 53 of this Petition, Sections 14, and 15 of Assembly Bill X3 5 are, singly and cumulatively, unlawful, in violation of the Americans with Disabilities Act of 1990, ("ADA"), 42 U.S.C. § 12132, which provides:

> "Subject to the provisions of this subchapter, no qualified individual with a disability shall, by reason of such disability, be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by any such entity(,"

in that the aforesaid 10% cut in Medi-Cal provider and hospital reimbursement of Sections 14 and 15 of Assembly Bill X3 5, will, singly, cumulatively, and proximately result in forcing, and threatening to force, thousands of persons who are qualified individuals with a disability, as defined in the ADA, into institutions, and place them at risk of being forced into institutions, in order to survive; and many will in any event be injured in their person and in their spirit and will die or be put at risk of dying; including but not limited to:

- the petitioners Margaret Dowling, Mark Beckwith, and Jason Young;
- hundreds of SSI recipients who are clients of the petitioner ILCSCal;
- many patients of the patients of the pharmacy petitioners,
- some members of the SF Gray Panthers and Sacto Gray Panthers,

so that therein, many qualified individuals with a disability, (as defined in the ADA), including but not limited to disabled SSI recipients who depend on Medi-Cal services to be able to live in the community, will be denied and will become unable to live in the **most integrated setting** appropriate to (1) the needs of those hundreds of thousands of Medi-Cal recipients who are SSI disabled persons, including (2) the needs of the disabled petitioners Margaret Dowling, Mark Beckwith, and Jason Young, and including (3) the needs of thousands of SSI disabled persons who are clients of the petitioner ILCSCal; and including (4) disabled patients of the pharmacy petitioners; **so that such administration of the Medi-Cal program does not provide qualified individuals with a disability the most integrated setting appropriate to their needs**, as mandated by the ADA, by *Olmstead v. L.C., supra,* 527 U.S. 581 (1999), and 28 Code of Federal Regulations, § 35.130(d). [1988].

55. Further, once the State has placed qualified individuals with a disability, (as defined by the ADA), in the community, including the petitioners Dowling, Beckwith, and Young, and the disabled persons listed in the preceding Paragraph; all, with medical, attendant, and other services and life-needed supplied furnished and paid by Medi-Cal fee-for-service and managed care program, or, assisted by these Medi-Cal programs of the State, so as to enable them to be so integrated into the community, the State has the burden, under the ADA, to justify and to show

reasonable grounds why such level, kinds, and quality of supporting services, assistance, and framework for independent living may be withdrawn by the State, as, in case at bar, by (1) provider payments for one month being arbitrarily and capriciously held for one month, and (2) provider and hospital payments being reduced 10%, permanently, by the State to Medi-Cal providers and Medi-Cal managed care plans, (which reductions to the managed care plans, will foreseeably and inevitably be passed through to the providers who provide the services of the Medi-Cal managed care plan to Medi-Cal recipients).

56. Therein and thereby, as set forth in the preceding Paragraphs of this Third Cause of Action, Secs. 14, and 15 of Assembly Bill X3 5 violate the ADA, and are preempted, under the Supremacy Clause, by the ADA specifically, by 42 U.S.C. § 12132, by forcing or threatening to force, individuals with a disability (as defined by the ADA), into institutions, and by putting them at risk to be forced into institutions, (including the petitioners Dowling, Beckwith, and Young, and the patients, clients, and members of the petitioner pharmacies, the ILCSCal, the Sacto Gray Panthers, and the SF Gray Panthers, – which is not the most integrated setting appropriate to their needs, as mandated by ADA and by *Olmstead v. L.C.*, *supra,* 527 U.S. 581.

Therein and thereby, the respondent Director and Department, by violating the ADA and of *Olmstead* on a statewide basis, are and will act in excess of

without jurisdiction to implement the aforesaid statutes (i.e., Secs. 14, and 15 of Assembly Bill X3 5).

57. Further, unless restrained by the Court by an appropriate writ of mandamus under § 1085 Code Civ. Proc. or by an appropriate injunction, the respondents Director and Department will implement the aforesaid Secs. 14, and 15 of Assembly Bill X3 5, and therein will cause each of the petitioners concrete injury, which is irreparable, as set forth in detail in the preceding Paragraphs of this Verified First Amended Petition for Writ of Mandamus; but, the petitioners have no administrative remedy, and no plain, speedy, or adequate remedy whatsoever or at all, except by this Verified First Amended Petition for Writ of Mandamus.

WHEREFORE, the Petitioners respectively pray for judgment as shall hereinafter be specified:

FOURTH CAUSE OF ACTION

Separate statement of violation of ADA

(By each petitioner against each respondent.)

58. Petitioners here refer to and incorporate each of the allegations in the preceding Paragraphs as if fully set forth herein.

59. Each and all of the acts of each of the respondents in violation of the ADA, which are set forth in the preceding Third Cause of Action, tend to force, do force, and threaten, to force qualified individuals

with a disability in the Medi-Cal program, – (including the petitioners Margaret Dowling, Mark Beckwith, and Jason Young, and the disabled patients, clients, and members of the remaining petitioners), – into institutions; all, in violation of the ADA (42 U.S.C. §12132) and *Olmstead, supra.* Accordingly, under the ADA, including 42 U.S.C. §§ 12123, and 12133, – which incorporates, via 29 U.S.C. § 794a(a)(2), the remedies of Title VI of the Civil Rights Act of 1964, (namely, 42 U.S.C. § 2000d-1 et seq.), – the petitioners herein have a federal right to an appropriate injunction herein to restrain the respondents from implementing Secs. 14, and 15 of Assembly Bill X3 5, plus, statutory reasonable attorneys's [sic] fees as provided by 42 U.S.C. § 12133.

WHEREFORE, the petitioners and each of them pray for judgment as follows;

1. That petitioners have judgment against each of the respondents, and that respondents take nothing.

First Cause of Action

2. That an alternative writ of mandamus, and then a peremptory writ of mandamus, and/or an injunction, be issued to command the respondents DEPARTMENT OF HEALTH CARE SERVICES ("Department") and SANDRA SHEWRY, Director of the Department, to set aside their preempted policy to implement subds. (a), (b)(1), (b)(2), and (c)-(e) of § 14105.19 Welf. & Inst. Code; and § 14166.245 Welf. & Inst. Code, and to refrain from implementing the

aforesaid subds. (a), (b)(1), (b)(2), and (c)-(e) of § 14105.19 Welf. & Inst. Code; and § 14166.245 Welf. & Inst. Code, including refraining from reducing payments by 10%, or at all, to providers in the Medi-Cal fee-for service program;

3. That petitioners have reasonable attorneys' fees under § 1021.5 Code Civ. Proc.

Second Cause of Action

4. That an alternative writ of mandamus, and then a peremptory writ of mandamus, and/or an injunction, be issued to command the respondents DEPARTMENT OF HEALTH CARE SERVICES ("Department") and SANDRA SHEWRY, Director of the Department, to set aside their preempted policy to implement subd. (b)(3) of § 14105.19 Welf. & Inst. Code, and to refrain from implementing the aforesaid preempted subd. (b)(3) of § 14105.19 Welf. & Inst. Code, including refraining from reducing payments to Medi-Cal managed care plans by 10%, or by the actuarial equivalent thereof, and in any other amount of payment reduction.

5. That petitioners have reasonable attorneys' fees under § 1021.5 Code Civ. Proc.

Third Cause of Action

6. That a writ of mandamus or injunction be issued to order the respondents DEPARTMENT OF HEALTH CARE SERVICES ("Department") and

SANDRA SHEWRY, Director of the Department, to set aside their preempted policy of implementing Sections 14, and 15 of Assembly Bill X3 5, and refrain from implementing the aforesaid preempted Sections 14, ands [sic] 15 of Assembly Bill X3 5, in whole or in part; including, refraining from educing [sic] payments by 10% or any other amount of reduction, to Medi-Cal providers in the Medi-Cal fee-for-service program, and Medi-Cal managed care plans, for dates of service on and after July 1, 2008, or at any other time.

7. That petitioners have reasonable attorneys' fees under § 1021.5 Code of Civil Procedure.

Fourth Cause of Action

8. That an injunction be issued under the Americans with Disabilities Act of 1990, ("ADA"), to command the respondents DEPARTMENT OF HEALTH CARE SERVICES ("Department") and SANDRA SHEWRY, Director of the Department, to refrain from implementing Secs. 14, and 15 of Assembly Bill X3 5, in whole and in every part, including, refraining from implementing a 10% reduction, or any other reduction in payments, to Medi-Cal fee-for-services providers and Medi-Cal managed care plans.

9. That petitioners have reasonable attorneys' fees under 42 U.S.C. § 12133.

All Causes of Action

10. That petitioners have costs of suit incurred, together with such other and further relief as may be just.

Dated: May 12, 2008.

LYNN S. CARMAN
STANLEY L. FRIEDMAN

By: /s/ Lynn S Carman
Attorneys for Petitioners Independent Living Center of Southern California, Inc.; Gray Panthers of Sacramento; The Gray Panthers of San Francisco; Gerald Shapiro, Pharm.D., dba Uptown Pharmacy & Gift Shoppe; Sharon Steen, dba Central Pharmacy; Tran Pharmacy, Inc., dba Tran Pharmacy; Margaret Dowling; Mark Beckwith; and Jason Young

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VERIFICATION

LYNN S. CARMAN deposes and says:

I am the attorney for the Petitioners in the within Verified First Amended Petition for Writ of Mandamus. I make this verification for the reason that the Petitioners are absent from the county where I have my office. I have read the pleading and I am informed and believe the matters therein to be true

and on that ground allege that the matters stated therein are true.

I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct. Executed in Novato, California, on May 12, 2008.

/s/ Lynn S Carman
LYNN S. CARMAN

* * *

UNITED STATES DISTRICT COURT
DISTRICT OF CALIFORNIA
WESTERN DIVISION

INDEPENDENT LIVING CENTER OF SOUTHERN CALIFORNIA, et al., Petitioners, vs. SANDRA SHEWRY, Director of Department of Health Services of the State of California, et al. Respondents.	Case No. CV 08-3315 CAS (MANx) ORDER DENYING PETITIONERS' MOTION FOR A PRELIMINARY INJUNCTION (Filed Jun. 25, 2008)

I. INTRODUCTION

On April 22, 2008, petitioners filed a verified petition for writ of mandamus in the Los Angeles County Superior Court, seeking mandamus and injunctive relief against the California Department of Health Care Services ("the Department"), Sandra Shewry, Director of the Department ("the Director"), and Does 1 through 50.[1] The Department is a California agency

[1] Petitioners are the Independent Living Center of Southern California, Inc.; Gray Panthers of Sacramento; the Gray Panthers of San Francisco; Gerald Shapiro, Pham.D., [sic] d/b/a Uptown Pharmacy and Gift Shoppe; Sharon Steen, d/b/a Central Pharmacy; Mark Beckwith; Margaret Dowling; Tran Pharmacy, Inc., d/b/a Tran Pharmacy; and Jason Young.

charged with the administration of California's Medicaid program, Medi-Cal. Petitioners are health care advocates and Medi-Cal providers and recipients.

On February 16, 2008, the California Legislature enacted Assembly Bill X3 5 ("AB 5") in special session. First Amended Petition ¶ 20. Section 14 of AB 5 adds Cal. Welf. & Inst. Code § 14105.19, which reduces by ten percent payments under the MediCal fee-for-service program for physicians, dentists, pharmacies, adult day health care centers, clinics, health systems, and other providers for services provided on or after July 1, 2008. Cal. Welf. & Inst. § 14105.19(b)(1); First Amended Petition ¶ 22. California Welfare & Institutions Code § 14105.19 also reduces payments to managed care plans by the actuarial equivalent of the ten percent payment reduction. Cal. Welf. & Inst. § 14105.19(b)(3); First Amended Petition ¶ 22. Section 15 of AB 5 adds Cal. Welf. & Inst. Code § 14166.245, which reduces payments to acute care hospitals not under contract with the Department for inpatient services provided on or after July 1, 2008. Cal. Welf. & Inst. § 14166.245(c); First Amended Petition ¶ 23.[2] These rate and

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[2] The Department is authorized to contract with individual hospitals for the exclusive right to treat Medi-Cal patients. Cal. Welf. & Inst. § 14081; *Cedars-Sinai Med. Ctr. v. Shewry*, 137 Cal. App. 4th 964, 969-70 (2006). Contracting hospitals are reimbursed by the Department at the negotiated contract rate, and, once the Department has contracted with enough hospitals to meet the needs of Medi-Cal beneficiaries in a geographic area, it awards no further contracts in that area. *Cedars-Sinai*, 137

(Continued on following page)

payment reductions are referred to herein as the "ten percent rate reduction."

Petitioners allege that the ten percent rate reduction violates Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 *et seq.* ("the Medicaid Act"), and therefore, may not be implemented. Petitioners seek declaratory relief and injunctive relief to restrain the implementation of the ten percent rate reduction.

On May 19, 2008, respondents removed this action to this Court, based on federal question jurisdiction. On May 28, 2008, petitioners filed the operative first amended petition against the Department and the Director. On June 1, 2008, petitioners voluntarily dismissed the Department as a respondent in this case without prejudice.

On May 30, 2008, petitioners filed the instant motion for preliminary injunction. Respondents filed their opposition thereto on June 12, 2008.[3] On June 16, 2008, petitioners filed a reply. A hearing was held on June 23, 2008, and the Court took this matter under submission. After carefully considering the parties' arguments, the Court denies petitioners' motion for the reasons set forth below.

Cal. App. 4th at 970. Noncontract hospitals are only reimbursed for treating Medi-Cal patients under certain circumstances, including where emergency care or services are provided. *Id.*

[3] By order dated June 19, 2008, the Court granted respondents' ex parte application to allow for the late filing of their instant opposition.

II. BACKGROUND

The Medicaid Act authorizes the federal government to distribute funds to participating states for the purpose of providing medical assistance to low income persons who are aged, blind, disabled, or members of families with dependent children. Medicaid is a cooperative federal program: the federal government provides federal funding to the states so that states may provide medical care to their needy citizens. State participation is voluntary; however, once a state chooses to participate by accepting federal funds, it must comply with requirements imposed by the Medicaid Act.

Because California has elected to participate in the Medicaid program, it must administer its state Medicaid program, known as Medi-Cal, in compliance with a state plan that has been pre-approved by the Secretary of the U.S. Department of Health and Human Services ("the Secretary"), and which complies with the requirements set forth in 42 U.S.C. § 1396a(a)(1)-(70). In accordance with these requirements, California must also provide methods and procedures for the payment of care and services that are consistent with efficiency, economy, and quality of care, and that ensure their availability to the Medicaid population to the same extent as they are available to the general population in the geographic area. 42 U.S.C. § 1396a(30)(A) ("§ (30)(A)").

Further, under California law, the Department must administer Medi-Cal in accordance with the

state plan; applicable state law, as specified in the Welfare and Institutions Code; and Medi-Cal regulations. Cal. Code Regs. tit. 22, § 50004(b).

Petitioners now move to preliminary enjoin the implementation of the ten percent rate reduction. The request for a preliminary injunction is predicated only on petitioners' first and second claims for relief.[4] In their first and second claims, petitioners allege the ten percent rate reduction violates 42 U.S.C. § 1396a(30)(A), which requires that a state plan must:

> provide such methods and procedures relating to the utilization of, and payment for, care and services available under the plan . . . as may be necessary . . . to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and

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[4] The first amended petition asserts four claims for relief. Petitioners' first claim is asserted by each of the petitioners except petitioner Jason Young. Petitioners' second claim is brought by petitioners Young and the Tran Pharmacy, Inc., d/b/a Tran Pharmacy. Petitioners third and fourth claims allege that §§ 14 and 15 of AB 5 are unenforceable because they are preempted by and violate the Americans with Disabilities Act (the "ADA"), 42 U.S.C. §§ 12181 *et seq.* However, because petitioners' motion for preliminary injunction is predicated only on the first and second claims, and only on their Supremacy Clause theory raised in their motion papers, those are the only claims and argument that the Court addresses herein.

services are available to the general population in the geographic area.

Petitioners allege that the Department and the Legislature improperly failed to consider efficiency, economy, and quality of care as required by § 30(A) in enacting the ten percent reduction, and that as a result of AB 5, there will not be a sufficient number of providers to provide equal access to healthcare as mandated by § 30(A).

III. LEGAL STANDARD

A preliminary injunction is appropriate when the moving party shows either (1) a combination of probable success on the merits and the possibility of irreparable harm, or (2) the existence of serious questions going to the merits and that the balance of hardships tips sharply in the moving party's favor. *See Rodeo Collection, Ltd. v. West Seventh,* 812 F.2d 1215, 1217 (9th Cir. 1987). These are not two distinct tests, but rather "the opposite ends of a single 'continuum in which the required showing of harm varies inversely with the required showing of meritoriousness.'" *Id.* A "serious question" is one on which the movant "has a fair chance of success on the merits." *Sierra On-Line, Inc. v. Phoenix Software, Inc.,* 739 F.2d 1415, 1421 (9th Cir. 1984).

IV. DISCUSSION

The "quality of care" provision of § (30)(A) provides that

> [a] State plan for medical assistance must . . . provide such methods and procedures relating to the utilization of and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care.

42 U.S.C. § 1396a(30)(A). The "equal access" provision of § 30(A) provides that

> [a] State plan for medical assistance must . . . provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are . . . sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

Id.

In *Sanchez v. Johnson,* 416 F.3d 1051 (9th Cir. 2005), the Ninth Circuit held that § 30(A) does not confer individual rights that are enforceable under 42 U.S.C. § 1983. *Id.* at 1060. There, plaintiffs,

consisting of a class of developmentally disabled individuals and several organizations, brought suit against California officials charged with the administration of programs for persons with developmental disabilities. *Id.* at 1053-54. The plaintiffs asserted claims under 42 U.S.C. § 1983, alleging that the defendants violated § 30(A) by failing to fund adequately community-based programs for persons with developmental disabilities. *Id.* at 1055. The district court found that in light of the Supreme Court's decision in *Gonzaga University v. Doe,* 536 U.S. 273 (2002), the Medicaid Act did not confer individual rights that were enforceable by recipients of Medicaid funding or providers of Medicaid services, under 42 U.S.C. § 1983.[5] *Id.* The district court therefore granted judgment on the pleadings in favor of the defendants. *Id.*

On appeal, the Ninth Circuit affirmed. The court reasoned that § 30(A) did not "focus[ ] on the rights of a specific class of beneficiaries." *id.* at 1059. The court found that instead, "§ 30(A) is concerned with overall methodology rather than conferring individually enforceable rights on individual Medicaid recipients." *Id.* at 1059-60. Because a plaintiff seeking to prosecute a claim under 42 U.S.C. § 1983 must "assert the violation of an individually enforceable *right* conferred specifically upon him, not merely a violation of

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[5] In *Gonzaga,* the Supreme Court clarified the standard for determining whether a federal statute creates rights enforceable under 42 U.S.C. § 1983.

federal law," and because § 30(A) does not manifest a congressional intent to confer individual rights, the court found that the Medicaid Act did not give rise to rights enforceable under 42 U.S.C. § 1983. *Id.* at 1062 (emphasis in original).[6]

It is true, as petitioners argue, that in *Sanchez* the Ninth Circuit was presented with the question of whether individuals may invoke 42 U.S.C. § 1983 to sue for an alleged violation of § 30(A). However, in order to decide that issue the Ninth Circuit was first required to determine whether § 30(A) gives rise to any federally created individual rights: in evaluating "whether a statutory violation may be enforced through § 1983 . . . [a court] must first determine whether Congress *intended to create a federal right*. *Gonzaga,* 536 U.S. at 283 (emphasis in original). Thus, in deciding that the *Sanchez* plaintiffs could not enforce § 30(A) under 42 U.S.C. § 1983, the Ninth Circuit necessarily concluded that § 30(A) does not create any individual federal rights.

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[6] The Court notes that there is a circuit split concerning whether plaintiffs can sue for alleged violations by state officials of § 30(A) under 42 U.S.C. § 1983. Specifically, the Fifth, Sixth, Ninth, and Tenth Circuit Courts of Appeal [sic] have found that Medicaid beneficiaries cannot sue for alleged violations of § 30(A) under 42 U.S.C. § 1983. On the other hand, the Eighth Circuit has concluded that § 30(A) creates individual rights that can be the subject of suit under 42 U.S.C. § 1983. There is currently pending a petition for certiorari to the Supreme Court from the judgment in the Fifth Circuit case, *Equal Access for El Paso, Inc. v. Hawkins,* 509 F.3d 697 (5th Cir. 2007), *cert. pending* (U.S. Supreme Ct. No. 07-1160) (filed March 10, 2008).

Because after *Sanchez,* petitioners do not have any claims for relief under 42 U.S.C. § 1983 by which to seek redress for violations of § 30(A), petitioners seek to avail themselves of a claim for relief allegedly arising directly under the Supremacy Clause, Article VI, § 2, of the United States Constitution. However, the Supremacy Clause, of its own force, does not create any rights enforceable under 42 U.S.C. § 1983. *See Golden State Transit Corp. v. L.A.,* 493 U.S. 103, 108 (1989) ("'[The Supremacy] clause is not a source of any federal rights'; it [']secures federal rights by according them priority whenever they come in conflict with state law.'") (quoting *Chapman v. Houston Welfare Rights Org.,* 441 U.S. 600, 613 (1979)).

In an attempt to avoid the effect of *Sanchez,* petitioners rely on cases following *Shaw v. Delta Air Lines,* 463 U.S. 85 (1983), to argue that AB 5 is preempted by the Medicaid Act, and therefore invalid under the Supremacy Clause, such that they are entitled to relief based on an implied right of action under the Supremacy Clause. In opposition, respondents argue that the Supremacy Clause does not confer any rights on petitioners. Respondents assert that petitioners therefore lack standing to maintain this suit.

In *Shaw,* the United States Supreme Court stated that

> [i]t is beyond dispute that federal courts have jurisdiction over suits to enjoin state officials from interfering with federal rights.

> A plaintiff who seeks injunctive relief from state regulation, on the ground that such regulation is pre-empted by a federal statute which, by virtue of the Supremacy Clause of the Constitution, must prevail, thus presents a federal question which the federal courts have jurisdiction under 28 U.S.C. § 1331 to resolve.

Shaw, 463 U.S. at 96 n.14; *see e.g., Verizon Md., Inc. v. Pub. Serv. Comm'n of Md.*, 535 U.S. 635, 641-43 (2002) (stating that the district court has federal question jurisdiction under 28. U.S.C. § 1331 in a suit where the plaintiff claimed that the Federal Communications Commission's order was preempted by federal law); *Lawrence County v. Lead-Deadwood School Dist.*, 469 U.S. 256, 259 n.6 (1985) (stating that the Eighth Circuit erroneously concluded that a district court lacked subject matter jurisdiction where the affected plaintiff school district alleged that a South Dakota statute conflicted with federal law and was therefore invalid under the Supremacy Clause); *see also Hydrostorage, Inc. v. Northern Cal. Boilermakers Local Joint Apprenticeship Comm.*, 891 F.2d 719 (9th Cir. 1989).

Shaw preemption claims have been permitted in three circumstances. First, where the plaintiff claims that a state law requires him to act in violation of federal law.[7] Second, such claims have been allowed

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[7] *See e.g., Lawrence County v. Lead-Deadwood School Dist. No. 40-1*, 469 U.S. 256, 258, 260-61 (1985) (after Lawrence

(Continued on following page)

where the plaintiff contends that his conduct will be restricted by a state law that is preempted by federal law.[8] Third, courts have entertained *Shaw*

County refused to distribute federal funds to the school district in accordance with a state statute, arguing that federal law gave it the discretion to spend the federal funds for any governmental purpose it chose, the school district filed suit seeking to compel Lawrence County to distribute the federal funds); *Burgio & Campofelice, Inc. v. N.Y. State Dep't of Labor*, 107 F.3d 1000, 1005-07 (2d Cir. 1997) (suit by a public works contractor to enjoin the New York Department of Labor from enforcing a state wage law, alleging the state law was preempted by ERISA); *Verizon Md., Inc. v. Public Serv. Comm'n of Md.*, 535 U.S. 635, 641-42 (2002) (Verizon sued the Maryland Public Service Commission alleging that the Federal Communications Commission's order requiring Verizon to make payments under a negotiated interconnection agreement violated the Telecommunications Act of 1996); *Qwest Corp. v. City of Santa Fe*, 380 F.3d 1258, 1264 (10th Cir. 2004) (suit by telecommunications provider challenging local ordinance that imposed several requirements on telecommunications providers before they could access city-owned rights-of-way).

[8] *See e.g., City of L.A. v. County of Kern*, 509 F. Supp. 2d 865, 889 (C.D. Cal. 2007) (where the plaintiffs challenged a local ordinance on that grounds that it was preempted by state law, the court analogized the law of preemption under the California Constitution to that under the Supremacy Clause, and held that the plaintiffs had standing to bring suit because their "conduct would be restricted by a local ordinance they challenge[d] as preempted, even if the plaintiffs d[id] not assert rights protected by the preempting statute itself"); *Planned Parenthood of Cent. Tex. v. Sanchez*, 280 F. Supp. 2d 590, 596, 599-602 (W.D. Tex. 2003) (family planning and abortion services provider challenged state statute that precluded payment of Medicaid funds to organizations providing abortions services); *St. Thomas – St. John Hotel & Tourism Ass'n, Inc. v. Gov't of U.S. Virgin Islands*, 218 F.3d 232, 240-42 (3d Cir. 2000) (challenge to territorial law

(Continued on following page)

preemption claims where state law interferes with federally created rights.[9]

Here, AB 5 neither compels nor restricts petitioners' own conduct. In order to state a claim, petitioners must therefore show that AB 5 interferes with some individual federal right that arises under § 30(A). However, for the reasons stated *supra*, § (30)(A) does not give rise to a federally created right.[10]

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providing that an employee discharged for any reason other than for cause as set forth in nine enumerated reasons will be considered to have been wrongfully discharged).

[9] *See e.g., League of Women Voters v. Blackwell,* 340 F. Supp. 2d 823, 827-28 (N.D. Ohio 2004) (challenge to Ohio Secretary of State's directive prescribing procedures for obtaining identification from first-time voters).

[10] Petitioners reliance on *Orthopaedic Hospital v. Belshe,* 103 F.3d 1491 (9th Cir. 1997), decided before *Sanchez,* is misplaced. There, the plaintiff-providers filed suit under 42 U.S.C. § 1983, claiming that the Director violated § 30(A) by setting reimbursement rates for hospital providers of outpatient services without considering hospital costs. *Orthopaedic Hosp.,* 103 F.3d at 1492. In that case, however, there was no discussion of whether plaintiffs had any federally created individual rights. However, because *Sanchez* has decided that no individual right to sue is conferred by § 30(A), it appears that the holding of *Orthopaedic Hospital* is not controlling on that issue.

The cases addressed by petitioners at the hearing held herein are similarly unavailing. In *Ball v. Rodgers,* 492 F.3d 1094 (9th Cir. 2007), the court, noting that after *Sanchez,* § 30(A) cannot be enforced under 42 U.S.C. § 1983, analyzed different provisions of the Medicaid Act, which it determined, unlike § 30(A), gave rise to individual rights. In *Day v. Apoliona,* 496 F.3d 1027 (9th Cir. 2007), the Ninth Circuit applied the

(Continued on following page)

Because petitioners do not have any federal rights under § 30(A), their probability of success on the claims at issue here is low, if not wholly lacking.[11]

See Golden State Transit Corp. v. L.A., 493 U.S. *supra* at 108 (1989) ("'[The Supremacy] clause is not a source of any federal rights'; it [']secures federal rights by according them priority whenever they come in conflict with state law.'") (quoting *Chapman v. Houston Welfare Rights Org.*, 441 U.S. 600, 613 (1979)).

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factors set forth in *Blessing v. Freestone*, 520 U.S. 329 (1997), and *Gonzaga University v. Doe*, 536 U.S. 273 (2002), to conclude that beneficiaries of a trust had individual rights that could be enforced under 42 U.S.C. § 1983. *Arc of Wash. State Inc. v. Braddock*, 427 F.3d 615 (9th Cir. 2005), involved a challenge under the ADA.

[11] Petitioners' reliance on *Burgio & Campofelice, Inc. v. New York State DOL*, 107 F.3d 1000 (2d Cir. 1997) is also misplaced. In *Burgio & Campofelice, Inc.*, the plaintiff argued that the allegedly preempted state statute improperly caused the withholding of money that it was due under a public works contract. *Burgio & Campofelice, Inc.*, 107 F.3d at 1005-06. In *Pharm. Research & Mfrs. of Am. v. Concannon*, 249 F.3d 66 (1st Cir. 2001), the First Circuit concluded that the plaintiff had standing to assert a claim under the Supremacy Clause reasoning that "[w]here a party has established a concrete injury in fact, and otherwise has standing to challenge the lawfulness of the statute, it is entitled to assert those concomitant rights of third parties that would be diluted or adversely affected should [its] constitutional challenge fail and the statute[] remain in force." *Id.* at 74 (internal quotations omitted; alterations in original). Here, § 30(A) does not give petitioners any right to Medi-Cal funds.

In light of the Court's finding that petitioners have no likelihood of succeeding on the merits, the Court, while acutely cognizant of the potential adverse consequences of the ten percent rate reduction, declines to address petitioners' arguments that they have shown irreparable harm. *See Global Horizons, Inc. v. United States DOL,* 510 F.3d 1054, 1058 (9th Cir. 2007) ("Once a court determines a complete lack of probability of success or serious questions going to the merits, its analysis may end, and no further findings are necessary.").

V. CONCLUSION

In accordance with the foregoing, the Court hereby DENIES petitioners' motion for preliminary injunction.

IT IS SO ORDERED.

Dated: June 25, 2008

/s/ Christina A. Snyder
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UNITED STATES
DISTRICT JUDGE

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IN THE UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF CALIFORNIA
WESTERN DIVISION

MANAGED PHARMACY CARE, a California corporation; INDEPENDENT LIVING CENTER OF SOUTHERN CALIFORNIA, INC., a California corporation; GERALD SHAPIRO, Pharm.D., doing business as Uptown Pharmacy & Gift Shoppe; SHARON STEEN, doing business as

No. CV09-0382 SJO PJWX

(Filed Jan. 16, 2009)

Central Pharmacy; and
TRAN PHARMACY, INC.,
a California corporation,

Plaintiffs,

-vs.-

DAVID MAXWELL-JOLLY,
Director of Department of
Health Care Services of the
State of California,

Defendant. /

The Plaintiffs complain of the defendant DAVID MAXWELL-JOLLY, Director of Department of Health Care Services of the State of California, and for claims for relief allege:

INTRODUCTION

1. Plaintiffs challenge the validity of the 5% reduction, under Assembly Bill ("AB") 1183, in reimbursement rates to providers of Pharmacy services to beneficiaries of the Medi-Cal fee-for-service program, for services furnished on or after March 1, 2009, which Defendant David Maxwell-Jolly, Director of the California Department of Health Care Services is responsible for implementing under AB 1183, and Welf. & Inst. Code 14105.

Jurisdiction and venue

2. The Court has jurisdiction under 28 U.S.C. § 1331. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96 n.4 (1983).

3. The actions of the Defendant complained were and will be done in all parts of the state of California, including the County of Los Angeles. The injuries which are inflicted and threatened which are complained of, to Plaintiffs, the members of Managed Care Pharmacy, and their patients in the Medi-Cal fee-for-service program, have occurred and are threatened to occur in all parts of the state of California, including the County of Los Angeles. The Defendant and the California Attorney General has an office in the County of Los Angeles.

Parties

4. The plaintiff MANAGED PHARMACY CARE ("MPC") is a California corporation, whose principal place of business is at Lake Arrowhead, California, and does business throughout California, including the County of Los Angeles, California. MPC has 284 pharmacy members throughout California, who are pharmacy providers in the Medi-Cal fee-for-service program.

5. (a) The plaintiff INDEPENDENT LIVING CENTER OF SOUTHERN CALIFORNIA, INC. ("ILCSCal") is a nonprofit California corporation which was duly organized and incorporated in California on

July 25, 1977 pursuant to the General Nonprofit Corporation Law of the State of California.

(b) ILCSCal has its principal office and place of business in, and does business in the County of Los Angeles, California.

6. (a) The plaintiff GERALD SHAPIRO, Pharm.D., is a duly licensed registered pharmacist with License No. 24377, who owns and operates a duly licensed retail pharmacy under the fictitious name of Uptown Pharmacy & Gift Shoppe, under retail pharmacy license No. PHY 41615, in the City of Los Angeles, California.

(b) The plaintiff SHAPIRO's pharmacy participates in the Medi-Cal fee-for-service program and also in Medi-Cal managed care plans, under Medi-Cal provider identification No. PHA 416150.

7. (a) The plaintiff SHARON STEEN is an individual who is a copartner in a copartnership which owns and operates a licensed retail pharmacy, under the fictitious name Central Pharmacy, under retail pharmacy license No. PHY 38051, in the City of Santa Monica, California.

(b) The plaintiff STEEN's pharmacy participates in the Medi-Cal fee-for-service program and also in Medi-Cal managed care plans, under Medi-Cal provider identification No. PHA 380510.

8. (a) The Plaintiff TRAN PHARMACY, INC. is California corporation which owns and operates a duly licensed retail pharmacy under the fictitious

name of Tran Pharmacy, under retail pharmacy license No. PHY 43647, in Garden Grove, California.

(b) The TRAN PHARMACY, INC.'s pharmacy participates in the Medi-Cal fee-for-service program and also in Medi-Cal managed care plans, under Medi-Cal provider identification No. PHA 436470.

9. (a) The Department of Health Care Services ("Department") is a department of the State of California. The Department administers the Medi-Cal program under § 14000 et seq. California Welfare and Institutions ("Welf. & Inst.") Code.

(b) The defendant DAVID MAXWELL-JOLLY, ("Director"), is the director of the Department. The Director is exclusively empowered by §§ 14100.1 and 14105 Welf. & Inst. Code to set all policies, rules and regulations in the Medi-Cal program, including all rates payable to Medi-Cal providers. The Director has an office in the County of Los Angeles. The Director is sued in his official capacity, only.

10. Plaintiffs are citizens and residents of the State of California, and sue herein on their own behalf, in their own interest, and in the interest of the members of MPC, and in the interests of the Medi-Cal patients of the Plaintiffs and the members of MPC, as well as also on behalf of the public of the State of California, to procure the performance of public duty by the defendant public official: namely the performance of the mandatory public duty of the Director, under and pursuant to the Supremacy

Clause, not to injure Medi-Cal beneficiaries and their providers, including Pharmacy providers, in the Medi-Cal FFS program, by implementing the federally preempted 5% Rate Reduction of AB 1183, – which aforesaid actions of the Director are preempted, under the Supremacy Clause, in that the aforesaid actions violate and are hence contrary to 42 U.S.C. § 1396a(a)(30)(A), – "Sec. 30A," – including the quality and equal access clauses of Sec. 30A.

11. Plaintiffs also sue in a prudential *jus tertii* capacity to assert their interests as well as the interests of the Medi-Cal patients of the Plaintiffs and the members of MPC, in the claims for relief, and Supremacy Clause preemption, which are sued upon and sought in this within intervention complaint.

12. Plaintiffs, – as well as the Pharmacy provider members of MPC, – and their Medi-Cal patients on behalf of whom Plaintiffs sue herein, – also have standing and a claim for relief against the Director inasmuch as each has suffered, will suffer, and is threatened to suffer, concrete and irreparable injury, unless the Defendant Director is restrained by an appropriate injunction from implementing the 5% Rate Reduction of AB 1183, which actions are preempted under the Supremacy Clause by Sec. 30A.

INTRODUCTION

13. Medi-Cal is a major component of the "safety net" that ensures the State's poor have access to health care services.

FIRST CLAIM FOR RELIEF

For injunctive relief to enjoin the Defendant to refrain from implementing AB 1183 and the 5% Rate Reduction

14. Plaintiffs refer to and incorporate each of the allegations in the preceding Paragraphs of this Complaint as if fully set forth herein.

LEGISLATIVE HISTORY OF ASSEMBLY BILL 1183

15. Assembly Bill ("AB") 1183, – a health trailer bill to implement the budget cutting decisions of the 2008-2009 Budget Bill, was enacted September 30, 2008 and was chaptered as Chapter 758, Statutes 2008-2009.

AB 1183

16. AB 1183 was introduced Feb. 2, 2008 as a hazardous material bill and was amended several times as solely a hazardous material bill. However, on September 15, 2008, the bill was amended in the Senate so as to be at once turned into a trailer bill, on many different subjects, to enact all provisions necessary to implement the provisions of the 2008-2009 Budget Bill; all without any public hearings or any hearing by any committee of the Legislature; was passed shortly before midnight of the same day of September 15, 2008 by the Senate; was sent to the Assembly, and was immediately passed by the

Assembly before 2:08 a.m. of September 16, 2008, – all within the space of a few hours, – and was signed by the Governor and filed with the Secretary of State on September 30, 2008.

17. By such legislative history, there were no committee hearings on AB 1183.

18. Further, there are hundreds of different health care subjects in AB 1183, each of which required separate consideration by the Legislature if any reasoned decision was to be made by any legislator in the Senate or the Assembly in deciding to vote for, or against particular provisions in the hundreds of different subjects contained in the bill. AB 1183 was hence the pure product of pure logrolling, where, if any member wished his or her health care provision in the multi-provisioned AB 1183 to be enacted, that legislator had to accept blindly all the other provisions relating to the hundreds of other subjects in the same bill.

19. It is a fact, and it is manifest from all the facts alleged in this First Claim for Relief, that individual legislators who voted on AB 1183, and the Legislature as a whole, could not and did not appropriately consider, and did not consider at all, whether or not the reduced rates of the 5% Rate Reduction for pharmacy services, and the reduced rates of the 5% Rate Reduction, were consistent with quality of services, or consistent with equal access of beneficiaries to quality services, in the Medi-Cal FFS program.

20. By each and all of the above facts, the action of the Legislature in enacting, and the action of the Director to implement, the 5% Rate Reduction provisions of AB 1183 were and are arbitrary, capricious, and contrary to law, (namely, contrary to the quality and equal clauses of Sec. 30A, and contrary to the requirement of Sec. 30A that a Medicaid rate setter consider the factors of quality and equal access of beneficiaries in the course of setting new Medi d rates for payment of providers); so that the provisions of (new) Welf. & Inst. Code § 14105.191 which enacted the 5% Rate Reduction in respect to Pharmacy services, effective March 1, 2009, violated and hence are preempted, under the Supremacy Clause, by Sec. 30A.

21. Further, unless restrained by the Court by an appropriate injunction, the defendant Director will implement the aforesaid 5% Rate Reduction in respect to Pharmacy services providers (including members of MPC); which in turn will thereby result in injury to the Plaintiffs; to the members of MPC; and to their Medi-Cal patients – which injury will foreseeably result in Pharmacy providers (including members of MPC) not accepting new Medi-Cal patients, or stopping serving Medi-Cal patients at all, or by reducing kinds, amounts, locations, and levels of services to Medi-Cal beneficiaries, or by going out of business, so that thereby Medi-Cal beneficiaries are and will be caused, and threatened to be caused, denial and reduction of access to life-vital Pharmacy services and treatment in the Medi-Cal FFS program,

resulting in great physical suffering and injury to beneficiaries, including beneficiaries who are patients of Plaintiffs and of the members of MPC; all to the irreparable injury, and threat of irreparable injury, to thousands of Medi-Cal beneficiaries including the beneficiaries served by Plaintiffs and the members of MPC.

22. Plaintiffs and the members of MPC,. and their Medi-Cal patients, have no administrative remedy, nor any plain, speedy, or adequate remedy whatsoever or at all, except by this complaint in intervention for injunctive relief.

WHEREFORE, Plaintiffs pray for judgment and orders as shall hereinafter be specified:

SECOND CLAIM FOR RELIEF

For injunctive relief to enjoin the Defendant to refrain from implementing the 5% Rate Reduction of Sec. 45 of AB 1183.

23. Plaintiffs refer to and incorporate each of the allegations in the preceding Paragraphs of this Petition as if fully set forth herein.

24. However, the enactment of the 5% Rate Reduction in respect to Pharmacy services and providers in the Medi-Cal HS program, of new Welf. & Inst. Code § 14105.191, by Sec. 45 of AB 1183, by the Legislature was without any consideration of quality

and equal access as required by Sec. 30A,[1] and was without any consideration of what it costs providers to perform the various services and procedures, as required by Sec. 30A;[2] such, that the State's sole purpose, and the conclusive factor, in enacting the 5% Rate Reduction was to reduce the budget deficit.

25. Accordingly, under the standard of *Orthopaedic Hosp.*, 103 F.3d 1491, at 1500 (1997), the action of the Legislature to enact the aforesaid provisions of § 14105.191 Welf. & Inst. Code, including the 5% Rate Reduction in respect to Pharmacy providers; and the policy and action of the Director to implement the 5% Rate Reduction, was and is arbitrary and capricious, and contrary to and in violation of the quality and access provisions of Sec. 30A.

26. Accordingly, by each and all of the foregoing facts alleged, new § 14105.191 Welf. & Inst. Code, and the 5% Rate Reduction in respect to Pharmacy providers, were and are contrary to and in violation of the quality and access provisions of Sec. 30A, so as to be preempted, under the Supremacy Clause, by the quality and access provisions of Sec. 30A, such that the Defendant Director is and will he acting in excess of and without jurisdiction to implement § 14105.191

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[1] *Othopaedic* [sic] *Hospital v. Belshe*, 103 F.3d 1491, 1500 (9th Cir.1997).

[2] *Id.*, 103 F.3d at 1500; *Arkansas Medical Society, Inc. v. Reynolds*, 6 F.3d 519 (8th Cir. 1993).

Welf. & Inst. Code, including the 5% Rate Reduction, to Pharmacy providers, commencing March 1, 2009.

27. Further, unless restrained by the Court by an appropriate injunction, the Defendant Director will implement the aforesaid § 14105.191 Welf. & Inst. Code, and the 5% Rate Reduction in payments to Pharmacy providers, commencing March 1, 2009, and thereby will cause injury to Plaintiffs; the members of MPC, and their Medi-Cal patients; which injury is irreparable, all, as has been hereinbefore set forth in detail in the within complaint in intervention.

28. Plaintiffs, the members of MPC, and their Medi-Cal patients, have no administrative remedy, nor any plain, speedy, or adequate remedy whatsoever or at all, except by this complaint in intervention for injunctive and declaratory relief.

WHEREFORE, Plaintiffs prays for judgment and orders as follows:

A. That Plaintiffs have judgment against the Defendant DAVID MAXWELL-JOLLY, Director of California Department of Health Services, (herein, "Director"), and that Defendants take nothing.

B. That a preliminary and permanent injunction be issued to command the Director DAVID MAXWELL-JOLLY to set aside his preempted policy to implement § 14105.19 Welf. & Inst. Code, of AB 1183, and the 5% Rate Reduction, and, to refrain from implementing the same; including but not limited to refraining from reducing payments by 5 percent or by

any other deduction, to pharmacy providers in the Medi-Cal FFS program, for services furnished on and after March 1, 2009.

C. That Plaintiffs have costs of suit incurred, together with such other and further relief as may be just.

LYNN S. CARMAN
STANLEY L. FRIEDMAN

By: /s/ Stanley L. Freidman
Attorneys for Plaintiffs

UNITED STATES DISTRICT COURT

NORTHERN DISTRICT OF CALIFORNIA

SANTA ROSA MEMORIAL HOSPITAL, et al., Plaintiffs, v. DAVID MAXWELL-JOLLY, Director the California Department of Health Care Services, Defendant.	Case No. 08-5173 BC ORDER DENYING APPLICATION FOR AN ORDER TO SHOW CAUSE; CLARIFYING PRELIMINARY INJUNCTION (Filed Dec. 10, 2009)

On December 8, 2009, Plaintiffs applied for an Order to Show Cause as to why David Maxwell-Jolly, Director of the California Department of Health Care Services ("DHCS"), should not be held in contempt for violating this Court's injunction of Medi-Cal reimbursement rate reductions. Docket No. 81 ("Application for OSC"). On December 9, 2009, Defendant filed an Opposition. Docket No. 82 ("Opp'n"). Having considered the papers submitted, the Court acknowledges that the text of its preliminary injunction is open to interpretation, and the Court therefore DENIES Plaintiffs' request for an order to show cause why the DHCS should not be held in contempt.

On November 18, 2009, the Court determined – based on binding Ninth Circuit precedent – that the Medi-Cal reimbursement rate reductions at issue violate federal law. Docket No. 68 ("Prelim. Inj.

Order"). Based on language submitted by Plaintiffs, the Court preliminarily enjoined the DHCS from continuing to implement and apply the ten percent reduction in the "allowable cost" reimbursement of the Plaintiffs for the inpatient services they provide to Medi-Cal patients. *Id.* at 14.

In response to the Order, the DHCS updated its website as follows:

> Pursuant to the November 18 order, when DHCS issues audited cost settlements for the plaintiff hospitals in *Santa Rosa,* it shall compensate them at 100 percent of their audited allowable costs for dates of service on or after November 18, 2009. The court's order does not affect interim payments to the plaintiff hospitals under Welfare and Institutions Code section 141666.245(b)(3).

Docket No. 81-1 ("Johnson Decl.") Ex. 1. Plaintiffs contend that the DHCS is violating the injunction by continuing to reduce its interim payments to Plaintiffs. Application for OSC at 2.

The Court now clarifies that its preliminary injunction was always intended to enjoin the ten percent reductions in both interim and final payments. In the Order, the Court quotes from both California Welfare & Institutions Code Section 14166.245(b)(1) regarding interim reimbursements, and Section 14166.245(c)(3) regarding final reimbursements. Order at 2. Throughout the Order, the

ORD
AND
BRIEFS

Nos. 09-958, 09-1158, and 10-283

Supreme Court, U.S.
FILED
MAY 19 2011
OFFICE OF THE CLERK

In the

Supreme Court of the United States

TOBY DOUGLAS, Director of the Department of Health Care Services, State of California,

v.

INDEPENDENT LIVING CENTER OF SOUTHERN CALIFORNIA, INC., A Nonprofit Corporation, et al.

TOBY DOUGLAS, Director of the Department of Health Care Services, State of California, et al.,

v.

CALIFORNIA PHARMACISTS ASSOCIATION, et al.

TOBY DOUGLAS, Director of the Department of Health Care Services, State of California,

v.

SANTA ROSA MEMORIAL HOSPITAL, et al.

On Writs of Certiorari to the United States Court of Appeals for the Ninth Circuit

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QUESTION PRESENTED

Under the Medicaid Act, 42 U.S.C. § 1396a(a)(30)(A), a state that accepts federal Medicaid funds must adopt a state plan containing methods and procedures to "safeguard against unnecessary utilization of . . . [Medicaid] services and . . . assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available . . . at least to the extent that such care and services are available to the general population." The Ninth Circuit, along with virtually all of the circuits to have considered the issue since this Court's decision in *Gonzaga University v. Doe*, 536 U.S. 273 (2002), concluded that this provision is not privately enforceable by providers or beneficiaries under 42 U.S.C. § 1983, *inter alia*, because it does not confer any "rights" on providers or beneficiaries, and because it requires balancing of indeterminate and potentially conflicting policy objectives that are "ill-suited" for judicial enforcement. Nonetheless, the Ninth Circuit held that such considerations were irrelevant in the present cases, where respondents are proceeding under the Supremacy Clause rather than under § 1983.

The question presented is:

Whether Medicaid recipients and providers may maintain a cause of action under the Supremacy Clause to enforce § 30(A) by asserting that the provision preempts a state law that may reduce payments to providers?

LIST OF PARTIES

No. 09-958 (*Indep. Living*)

Petitioner is Toby Douglas (formerly David Maxwell-Jolly), Director of the Department of Health Care Services, State of California (DHCS).

Respondents who were plaintiffs-appellees below are Independent Living Center of Southern California, Inc., a nonprofit corporation; Gray Panthers of Sacramento, a nonprofit corporation; The Gray Panthers of San Francisco, a nonprofit corporation; Gerald Shapiro, Pharm.D., d/b/a Uptown Pharmacy and Gift Shoppe; Sharon Steen, d/b/a Central Pharmacy; Mark Beckwith; Margaret Dowling; and Tran Pharmacy, Inc., a corporation d/b/a Tran Pharmacy.

Respondents who were intervenor-appellees below are Sacramento Family Medical Clinics, Inc.; Theodore M. Mazer, M.D.; Ronald B. Mead, D.D.S.; and Acacia Adult Day Services.

No. 09-1158 (*Cal. Pharm.*)

Petitioners are Toby Douglas (formerly David Maxwell-Jolly), Director of DHCS; William Lightbourne (formerly John A. Wagner), Director of the Department of Social Services, State of California; and Edmund G. Brown Jr. (formerly Arnold Schwarzenegger), Governor of the State of California.

California Pharmacists respondents are California Hospital Association; Sharp Memorial Hospital; Grossmont Hospital Corporation; Sharp Chula Vista

LIST OF PARTIES – Continued

Medical Center; Sharp Coronado Hospital and Healthcare Center; Acacia Adult Day Services; California Association for Adult Day Services; Fe Garcia; and Charles Gallagher.[1]

Independent Living respondents are Independent Living Center of Southern California, Inc., a nonprofit corporation; Gerald Shapiro, Pharm.D., d/b/a Uptown Pharmacy and Gift Shoppe; Sharon Steen, d/b/a Central Pharmacy; and Tran Pharmacy, Inc., d/b/a Tran Pharmacy.

Dominguez respondents are Lydia Dominguez (now deceased); Patsy Miller; Alex Brown, by and through his mother and next friend Lisa Brown; Donna Brown; Chloe Lipton, by and through her conservator and next friend Julie Weissman-Steinbaugh; Herbert M. Meyer; Leslie Gordon; Charlene Ayers; Willie Beatrice Sheppard; Andy Martinez; Service Employees International Union United Healthcare Workers West; Service Employees International Union United Long-Term Care Workers; Service Employees International Union Local 521;

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[1] The petition named an additional six respondents: the California Pharmacists Association, California Medical Association, California Dental Association, Marin Apothecary, Inc. d/b/a Ross Valley Pharmacy, South Sacramento Pharmacy, and Farmacia Remedios, Inc. Those entities were plaintiffs in the district court, but were not parties in the court of appeals, and thus are not respondents under this Court's Rule 12.6.

LIST OF PARTIES – Continued

and Service Employees International Union California State Council.

No. 10-283 (*Santa Rosa*)

Petitioner is Toby Douglas (formerly David Maxwell-Jolly), Director of DHCS.

Respondents are Santa Rosa Memorial Hospital; St. Helena Hospital; Queen of the Valley Medical Center; Central Valley General Hospital; San Joaquin Community Hospital; San Antonio Community Hospital; Children's Hospital at Mission; Saddleback Memorial Medical Center; Orange Coast Memorial Medical Center; Anaheim Memorial Medical Center; Hoag Memorial Hospital Presbyterian; Heart Hospital of BK, LLC; John Muir Health; SRM Alliance Hospital Services; Lancaster Hospital Corporation; Fountain Valley Regional Hospital and Medical Center; and Mission Hospital Regional Medical Center.

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OPINIONS BELOW

No. 09-958 (*Indep. Living*). This petition seeks review of two opinions of the Ninth Circuit Court of Appeals, one reported at 572 F.3d 644, *Indep. Living* Pet. App. 1, and one not reported, *id.* at 54. A prior Ninth Circuit opinion in the case is reported at 543 F.3d 1050, *Indep. Living* Pet. App. 58. The district court opinions that led to the Ninth Circuit decisions, *id.* at 94, 125, 127, 133, are unreported.

No. 09-1158 (*Cal. Pharm.*). This petition seeks review of four opinions issued by the Ninth Circuit on March 3, 2010. Two of the opinions are reported, 596 F.3d 1098 and 596 F.3d 1087. *Cal. Pharm.* Pet. App. 1, 59. Two of the opinions are not reported. *Id.* at 37, 53. In one of the appeals, *see id.* at 37, the Ninth Circuit previously had issued an order granting an injunction pending appeal, *id.* at 42, which is reported at 563 F.3d 847. Three of the district court opinions that led to the Ninth Circuit decisions, *Cal. Pharm.* Pet. App. 84, 106, and 128, are reported at, respectively, 630 F. Supp. 2d 1144, 630 F. Supp. 2d 1154, and 603 F. Supp. 2d 1230, while the remainder are not reported. *Cal. Pharm.* Pet. App. 152, 161, 176, 178, 180.

No. 10-283 (*Santa Rosa*). This petition seeks review of an unreported decision of the Ninth Circuit. *Santa Rosa* Pet. App. 1. The district court orders that led to the Ninth Circuit's opinion also are unreported. *Id.* at 5, 7, 9.

JURISDICTION

This Court has jurisdiction under 28 U.S.C. § 1254(1).

The Ninth Circuit issued the opinions at issue in No. 09-958 (*Indep. Living*) on July 9, 2009 and August 7, 2009, and denied the Department of Health Care Service's (DHCS's) Petitions for Rehearing and Rehearing En Banc on, respectively, October 29, 2009 and September 23, 2009. The petition was timely filed on February 16, 2010, following orders extending the time to file.

The Ninth Circuit issued the four opinions at issue in No. 09-1158 (*Cal. Pharm.*) on March 3, 2010, and the petition for writ of certiorari was filed on March 24, 2010.

The Ninth Circuit issued the opinion at issue in No. 10-283 (*Santa Rosa*) on May 27, 2010, and the petition for writ of certiorari was filed on August 25, 2010.

STATUTORY AND REGULATORY PROVISIONS INVOLVED

The Supremacy Clause of the United States Constitution states:

> This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the

> United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.

U.S. Const., art. VI, cl. 2.

The Medicaid Act, 42 U.S.C. § 1396a(a)(30)(A), states in pertinent part:

> (a) Contents
>
> A State plan for medical assistance must –
>
> * * *
>
> (30)(A) provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area . . . .

The state statutory reductions at issue are reproduced in the appendices to the petitions for certiorari in these consolidated cases, as follows:

No. 09-958 (*Indep. Living*)

Cal. Welf. & Inst. Code § 14105.19(b)(1) (enacted Feb. 16, 2008), reproduced at *Indep. Living* Pet. App. 158; *see also Indep. Living* Pet. App. 162.

No. 09-1158 (*Cal. Pharm.*)

Cal. Welf. & Inst. Code § 14105.191(b)(2)(F) (enacted Sept. 30, 2008), reproduced at *Cal. Pharm.* Pet. App. 205-06 (at issue in 9th Cir. No. 09-55532).

Cal. Welf. & Inst. Code §§ 14105.191(b)(1), 14105.191(b)(2)(B), (D), (E), 14166.245(b)(2)(A), (c)(3)(B) (enacted Sept. 30, 2008), reproduced at *Cal. Pharm.* Pet. App. 205-06, 211, 213-14 (at issue in 9th Cir. No. 09-55365).

Cal. Welf. & Inst. Code § 14105.191(b)(3) (enacted Sept. 30, 2008), reproduced at *Cal. Pharm.* Pet. App. 206 (at issue in 9th Cir. No. 09-55692).

Cal. Welf. & Inst. Code § 12306.1(d)(6) (enacted Feb. 20, 2009), reproduced at *Cal. Pharm.* Pet. App. 224 (at issue in 9th Cir. No. 09-16359).

No. 10-283 (*Santa Rosa*)

Cal. Welf. & Inst. Code § 14166.245(b), (c)(3) (enacted Feb. 16, 2008), reproduced in *Santa Rosa* Pet. App. 25-26; *see also Santa Rosa* Pet. App. 28, 31, 35, 38.

STATEMENT OF THE CASE

Facing a devastating, ongoing, and deepening financial crisis, the California Legislature enacted a series of statutory reforms directed towards reducing the costs and increasing the efficiency of the State's Medicaid program, known as Medi-Cal. At issue here are reductions that the Legislature enacted in 2008 and 2009 to payments made to certain types of Medicaid providers (e.g., pharmacists, Adult Day Health Centers (ADHCs), and hospitals for various types of services), and a reduction enacted in 2009 to the State's contribution to rates paid by counties to providers of In-Home Supportive Services (IHSS).

The Ninth Circuit affirmed injunctions of, or ordered enjoined, all of the enactments challenged by respondents on the ground that they are preempted by 42 U.S.C. § 1396a(a)(30)(A) (hereinafter, § 30(A)). The court recognized that § 30(A) does not confer any "rights" that may be enforced by private parties under 42 U.S.C. § 1983. The court held, nonetheless, "that 'a plaintiff seeking injunctive relief under the Supremacy Clause on the basis of federal preemption need not assert a federally created "right," in the sense that term has recently been used in suits brought under § 1983.'" *Cal. Pharm.* Pet. App. 46; *see also Indep. Living* Pet.74-75, 83-84, 92-93. The issue thus presented is whether private parties may assert a preemption claim under the Supremacy Clause to enforce a federal Spending Clause statute, § 30(A), where, *inter alia*, Congress itself has not created a private cause of action to enforce the statute;

Congress has vested enforcement of the statute in an administrative agency; the legislative history confirms congressional intent to preclude, rather than permit, private challenges; and this Court repeatedly has held that the Supremacy Clause does not create any rights.

A. Statutory and Regulatory Background

Medicaid is a cooperative federal-state program that provides federal financial assistance to participating states to reimburse providers for covered health care services rendered to Medicaid-eligible individuals. 42 U.S.C. §§ 1396 *et seq*. A state's participation in Medicaid is voluntary, but if it chooses to participate, it must comply with the Medicaid Act and implementing regulations promulgated by the Secretary of the United States Department of Health and Human Services (HHS). *See Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 502 (1990).

To receive funds, a state must administer its Medicaid program through a state plan approved by HHS. 42 U.S.C. § 1396a. The federal statute at issue here requires that a state plan for medical assistance

> provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough

> providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

42 U.S.C. § 1396a(a)(30)(A).

A state may modify its state plan by submitting a state plan amendment (SPA) to the Centers for Medicare & Medicaid Services (CMS) for approval. 42 C.F.R. §§ 430.12 *et seq*. Anticipating that compliance issues might arise, Congress provided for an administrative remedy should a state be found not in compliance with its plan: "after reasonable notice and opportunity for hearing," HHS may withhold or limit "further payments" to a state until it is satisfied with the state's compliance. 42 U.S.C. § 1396c; *see also* 42 C.F.R. § 430.35. Under HHS regulations, if a state's Medicaid expenditures are disallowed by HHS, the state may repay the funds through an "adjustment" to a "subsequent grant award." 42 C.F.R. §§ 430.33(c)(3), 430.42(a), (d); *see also id.* § 430.35(d). Alternatively, a state may arrange to repay disallowed funds in installments. *Id.* § 430.48. If a state disagrees with a notice of disallowance (or of disapproval of a SPA), it may request an administrative hearing. *Id.* §§ 430.60 *et seq*.

Private parties, such as Medicaid beneficiaries and providers, may participate in such hearings, either as "parties" or as "amicus curiae," depending on the nature of their interests in the matter. 42

C.F.R. § 430.76.[2] In connection with such hearings, CMS (and any party) may conduct discovery and offer evidence, including expert opinion testimony. *Id.* §§ 430.83, 430.86, 430.88. A state may appeal an adverse final determination to the United States Court of Appeals for the circuit in which the state is located. *Id.* §§ 430.38, 430.102. Private parties may appeal only if they fall within the zone of interests sought to be protected by the statutory provision at issue. *See* 5 U.S.C. § 704; *Bennett v. Spear*, 520 U.S. 154, 175-76 (1997).

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[2] Respondents (and some of the amici in the present cases) are actively participating as amici in CMS's administrative proceedings with respect to the SPAs at issue in these cases. *See, e.g.*, Joint Petition for Participation in Administrative Hearing, *In re Reconsideration of Disapproval of California State Plan Amendments* (HHS Jan. 3, 2011) (submitted on behalf of, *inter alia*, California Hospital Association, California Pharmacists Association, and Independent Living Center of Southern California); AARP's Application for Leave to File *Amicus Curiae* Brief and Proposed *Amicus Curiae* Brief Urging Affirmance of CMS' Decision Disapproving Proposed California State Plan Amendments, *In re Reconsideration of Disapproval of California State Plan Amendments* (HHS Feb. 3, 2011); Letter from Mary Staples, Regional Director, State Government Affairs, National Association of Chain Drug Stores, to Benjamin Cohen, Presiding Officer, Centers for Medicare and Medicaid Services (Jan. 5, 2011). CMS has approved the petitions to file amicus briefs. *See* Email from Benjamin R. Cohen, Presiding Officer, to David Hoskins *et al.*, Re: Petitions to Participate in Hearing on Reconsideration of California State Plan Amendments (Feb. 10, 2011).

B. Facts

Respondents challenge three sets of Medicaid reforms that California enacted in February 2008, September 2008, and February 2009, as part of a comprehensive, and continuing, effort to address the State's daunting fiscal crisis in a responsible manner. Most of the reforms reduced payments to providers of various types of services by a percentage, ranging from 1% to 10% depending on the nature of the service or type of provider. *See, e.g.*, Cal. Welf. & Inst. Code §§ 14105.19(b)(1), 14166.245(b), (c)(3) (Feb. 2008); *id.*, §§ 14105.191(b)(1)-(3), 14166.245(b), (c) (Sept. 2008). One set of reforms did not reduce payments to providers, but instead reduced the State's maximum contribution to wages and benefits paid by the counties to Medicaid providers of In Home Supportive Services. *Id.*, § 12306.1(d)(6) (Feb. 2009). The methodology for determining overall payments for such services (i.e., collective bargaining between counties and unions) did not change. *Cal. Pharm.* Pet. App. 63-64, 66, 163-64.[3]

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[3] As petitioners previously advised the Court, the reductions at issue in *Independent Living*, S. Ct. No. 09-958, sunset on February 28, 2009, although that petition continues to present a live controversy because the State challenges the propriety of overpayments that it made to providers as a result of improper injunctions affirmed in the underlying appeals, and because the issues raised are recurring. *See Indep. Living* Pet. App. 44-48. Moreover, the district court has stayed *Independent Living*, including certain providers' already-filed motion seeking additional retroactive relief with respect to the statutory reductions

(Continued on following page)

C. Proceedings Below

In the seven decisions at issue in these three consolidated petitions for certiorari, the Ninth Circuit affirmed every district court order granting an

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that sunset on February 28, 2009, pending a decision from this Court on whether a Supremacy Clause claim may be maintained. *Indep. Living Ctr. of So. Cal. v. Shewry*, No. CV 08-3315 (C.D. Cal. June 17, 2010) (order granting DHCS's application for stay of trial court proceedings). In March and April 2011, the California Legislature enacted legislation that will affect some of the reductions at issue in *California Pharmacists*, S. Ct. No. 09-1158, and *Santa Rosa*, S. Ct. No. 10-283, including (1) new reductions that will replace the AB1183 reductions upon federal approval; and (2) elimination of the AB5 reductions and AB1183 CMAC-5% cap on payments to noncontract hospitals for inpatient services beginning April 13, 2011. *See* Cal. Welf. & Inst. Code §§ 14105.191, 14105.192 (as amended and enacted by Cal. Stats. 2011, ch. 3 (A.B.97), §§ 93.2, 93.5); *id.* § 14166.245(j) (as amended by Cal. Stats. 2011, ch. 19 (S.B.90), § 4). The Legislature also provided that the AB1183 reductions will become "inoperative for dates of service after June 1, 2011," *see* Cal. Welf. & Inst. Code § 14105.191(j) (as amended by Cal. Stats. 2011, ch. 3 (A.B.97), § 93.2), although DHCS anticipates trailer bill legislation to clarify that the AB1183 reductions will remain in place until new rate reductions take effect following federal approval. The *California Pharmacist* and *Santa Rosa* petitions (along with *Independent Living*) continue to present live controversies because (1) the changes are contingent on events that have not yet occurred, such as federal approval; (2) even after the changes take effect, the propriety of overpayments that the State contends it has made pursuant to injunctions entered in those cases will remain live, as it does in *Independent Living*; and (3) the issue raised herein will recur until or unless it is resolved by this Court. *See Cal. Pharm.* Pet. App. 228-42 (describing dozens of Supremacy Clause cases filed in the wake of *Independent Living I*).

injunction, and reversed the one district court order denying an injunction. *See Cal. Pharm.* Pet. 37, 106. As a consequence, every Medicaid reform challenged by private parties on appeal has now been enjoined.

The Ninth Circuit first recognized a Supremacy Clause cause of action to enforce § 30(A) in *Independent Living Center of Southern California v. Shewry*, 543 F.3d 1050 (9th Cir. 2008) (*Independent Living I*), *see Indep. Living* Pet. App. 58, a precursor to the appeals at issue in No. 09-958 (*Independent Living II* and *III*). The court recognized that, pursuant to its prior decision in *Sanchez v. Johnson*, 416 F.3d 1051 (9th Cir. 2005), § 30(A) does not confer any "rights" on private parties that are enforceable under § 1983. *Id.* at 65-66, 92-93.[4] Consistent with *Sanchez*, the court acknowledged that respondents "do not seek to enforce any substantive 'right' conferred by statute." *Indep. Living* Pet. App. 92-93. However, it characterized DHCS's reliance on *Sanchez* as "misplaced," because "our decision in [*Sanchez v.*] *Johnson* had nothing to say about a claim for injunctive relief brought under the Supremacy Clause." *Id.* at 87. The court thus sidestepped *Sanchez* by "holding that a party may seek injunctive relief under the Supremacy

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[4] In *Sanchez*, the Ninth Circuit had held that § 30(A) cannot be enforced by Medicaid beneficiaries or providers under § 1983 because it does not confer any "rights" on any private parties and because it requires balancing of "indeterminate and competing" policy objectives that are "ill-suited" for judicial enforcement. 416 F.3d at 1059-62.

Clause regardless of whether the federal statute at issue confers any substantive rights on would-be plaintiffs." *Indep. Living* Pet. App. 83; *see also id.* at 84 (holding "the 'rights' requirement inapplicable to ILC's claims in this case"). In support, the Ninth Circuit noted that this Court "has repeatedly entertained claims for injunctive relief based on federal preemption, without requiring that the standards for bringing suit under § 1983 be met." *Id.* at 68; *see also id.* at 68-83 (citing, *inter alia*, *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983); *Pharm. Research & Mfrs. of Am. v. Walsh*, 538 U.S. 644 (2003)). DHCS filed a petition for certiorari seeking review of this decision, which the Court denied on June 22, 2009 (S. Ct. No. 08-1223).

The petition in *Independent Living* (S. Ct. No. 09-958) concerns appeals from the district court's decisions on remand of *Independent Living I*. On August 18, 2008 and November 17, 2008, the district court entered two orders enjoining DHCS from implementing payment reductions as to, *inter alia*, pharmacists, physicians, dentists, ADHCs, and providers of non-emergency transportation services and home health services. *Indep. Living* Pet. App. 94, 133. On August 27, 2008, the district court amended its August 18, 2008 injunction to provide only prospective relief. *Id.* at 125-26.

On appeal, the Ninth Circuit affirmed both district court injunctions. *Indep. Living* Pet. App. 1, 54 (*Independent Living II* and *III*). The court acknowledged that § 30(A) "does not create any

federal 'rights' enforceable under § 1983." *Indep. Living* Pet. App. 13, n.10 & 15-16 (citing *Sanchez*). But the court denied as "moot" DHCS's effort to reargue whether private parties may sue to enforce § 30(A) under the Supremacy Clause, citing its decision in *Independent Living I*. *Id.* at 8 n.7. The court also reversed the district court's August 27, 2008 order, and held that providers in *Independent Living II* were entitled to retroactive damages from the date that the reductions at issue in that case took effect (i.e., July 1, 2008) until the injunctions were entered. *Id.* at 29-37; *see also id.* at 46-47.

In the *California Pharmacists* appeals (No. 09-1158), the Ninth Circuit applied and expanded on its theory. DHCS had opposed the injunctions in those cases contending, *inter alia*, that providers' economic injury is not a harm that § 30(A) was designed to protect against. In rejecting this argument, the Ninth Circuit reiterated "that 'a plaintiff seeking injunctive relief under the Supremacy Clause on the basis of federal preemption need not assert a federally created "right," in the sense that term has recently been used in suits brought under § 1983, but need only satisfy traditional standing requirements.'" *Cal. Pharm.* Pet. App. 46. The court then elaborated: "A cause of action based on the Supremacy Clause obviates the need for reliance on third-party rights because the cause of action is one to enforce the proper constitutional structural relationship between the state and federal governments and therefore is

not rights based." *Id.* at 47; *see also id.* at 32-33, 38-39.[5] Instead, "private parties [may] enforce the structural relationship between the federal and state governments . . . as, essentially, private enforcers of the Supremacy Clause; the specific relationship of those parties to the federal statute on which the Supremacy Clause cause of action is premised does not matter." *Id.* at 48.

SUMMARY OF ARGUMENT

Congress must create any private cause of action to enforce a federal statute. *Gonzaga Univ. v. Doe*, 536 U.S. 273, 280, 283 (2002); *Alexander v. Sandoval*, 532 U.S. 275, 286 (2001). The Ninth Circuit and respondents acknowledge that Congress has not created a private cause of action to enforce § 30(A). Nonetheless, the Ninth Circuit held in these cases that the Supremacy Clause creates a private cause of action to enforce § 30(A) against a state, and that "rights" and congressional intent are irrelevant to whether such a cause of action exists. The Ninth Circuit is wrong: the Supremacy Clause cannot, by itself, create a cause of action, and any cause of action to enforce a federal statute must come from Congress. Were it to stand, the Ninth Circuit's analysis would

[5] The remaining Ninth Circuit decisions at issue in S. Ct. Nos. 09-1158 and 10-283 applied *Independent Living I* without further analysis. Except for the unpublished decision in *Santa Rosa*, all of the decisions were issued by the same panel that decided *Independent Living I*.

fundamentally alter the traditional separation of powers among the branches and transform the courts into all-purpose regulatory enforcers of Spending Clause enactments.

I.a. Congress's exclusive prerogative to determine who may enforce federal statutes, and how, is well-settled. *Sandoval*, 532 U.S. 275; *see also Astra USA, Inc. v. Santa Clara County*, 131 S. Ct. 1342, 1347 (2011); *Gonzaga*, 536 U.S. at 280. Where (as here) Congress has not expressly created a private cause of action to enforce a federal statute, this Court has required private parties to demonstrate, *inter alia*, that Congress created an individualized "right" in favor of plaintiffs, and that Congress intended to provide a private remedy. *Cort v. Ash*, 422 U.S. 66, 78 (1975); *see also Gonzaga*, 536 U.S. at 282. These principles are grounded in separation of powers, and prevent the judiciary from becoming embroiled in disputes that Congress has not assigned to it. *Stoneridge Inv. Partners, LLC v. Scientific-Atlanta*, 552 U.S. 148, 164-65 (2008).

b. Under a straightforward application of this Court's precedent, § 30(A) may not be enforced by private parties. Section 30(A) does not contain an express cause of action, nor does it satisfy the requirements for private enforcement under § 1983 or *Cort v. Ash*, as respondents concede. *See Gonzaga*, 536 U.S. at 280-86, 290; *Cort*, 422 U.S. at 78. Although the Ninth Circuit recognized that § 30(A) does not confer any privately enforceable rights, that court held that private parties can enforce it anyway, under

the Supremacy Clause. The Ninth Circuit did not grapple with *Gonzaga*, but simply dismissed such precedent as irrelevant. *See Cal. Pharm.* Pet. App. 48; *see also Indep. Living* Pet. App. 87. Because Congress did not create a cause of action to enforce § 30(A), an essential fact that no one disputes, the present cases should be dismissed under a straightforward application of *Gonzaga* and *Cort*.

c. Implying a cause of action to enforce § 30(A) would frustrate, rather than further, congressional intent, in numerous respects. Contrary to congressional intent, private suits have driven up Medicaid costs in California and elsewhere; undermined the national uniformity of federal Medicaid requirements; and resulted in an unworkable regulation-by-injunction system in which the States cannot predict their Medicaid costs with accuracy and are subjected to massive unfunded liabilities when they guess incorrectly what a court might do. Moreover, private lawsuits interfere with the administrative enforcement mechanism that Congress created to ensure the States' compliance with the Medicaid Act. The injunctions issued in the present cases, for example, have prejudiced California in the administrative proceedings pending as to the reductions at issue, because they have caused CMS to become concerned about retroactive liability that providers might face if it approves the SPAs. *See* Brief for the United States as Amicus Curiae, App. 3a, *Independent Living*, S. Ct. No. 09-958 (filed Dec. 3, 2010). The legislative history does not contain any hint that Congress intended for

private parties to enforce § 30(A). To the contrary, in 1997 Congress repealed a different Medicaid provision (the Boren Amendment) in an effort to preclude exactly the type of challenge to Medicaid ratemaking that private parties are now seeking to assert under § 30(A).

II. Respondents cannot obtain a different result by recasting their claims to sound in preemption. Whether characterized as § 1983 claims or preemption claims, respondents' efforts to enforce § 30(A) "are in substance one and the same," and "[t]heir treatment, therefore, must be the same, '[n]o matter the clothing in which [private parties] dress their claims.'" *Astra*, 131 S. Ct. at 1345 (quoting *Tenet v. Doe*, 544 U.S. 1, 8 (2005)). Private parties should not be able to use the Supremacy Clause to effectuate an end run around *Gonzaga*, *Cort*, *Sandoval*, and congressional intent.

a. The Supremacy Clause cannot supply a cause of action to enforce a federal statute because the Clause does not confer any substantive "rights." *See Golden State Transit Corp. v. City of Los Angeles*, 493 U.S. 103, 107 (1989); *Chapman v. Houston Welfare Rights Org.*, 441 U.S. 600, 613 & n.29 (1979); *see also Dennis v. Higgins*, 498 U.S. 439, 450 (1991). Rather, the history of its adoption, its placement in Article VI, and this Court's precedent all confirm a different role for the Clause: it supplies a rule of decision – that federal law trumps conflicting state law – in cases that are properly before a court. Without a declaration of supremacy, the Framers were concerned that

state court judges might continue to apply a then existing rule of construction that, among "equal" sovereigns, a later enactment trumps an earlier enactment. *The Federalist* No. 78, at 394-95 (I. Shapiro ed., 2009) (Alexander Hamilton); James Madison, Vices of the Political System of the United States (1787), *in* 2 *The Writings of James Madison* 364-65 (G. Hunt ed., 1901). Thus, to the Framers' thinking, the Supremacy Clause merely confirmed a self-evident truth (the supremacy of federal law) that flows from the nature of a national government. *The Federalist* No. 33, at 159, 161 (Alexander Hamilton).

b. Moreover, the Supremacy Clause and preemption have no role in a dispute over a state's compliance with a funding condition set forth in a Spending Clause statute. The relationship between the federal and state governments in this context is defined *not* by the supremacy of federal law, but by the quasi-contractual agreement between the governments. *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981). After all, through the Spending Clause, Congress may entice states to voluntarily accept obligations that it could not directly mandate. *N.Y. v. United States*, 505 U.S. 144, 166-67 (1992). If a state fails to comply with a federal condition for receiving federal funding under the Medicaid Act, the state is not in "conflict" with federal law, as Congress expressly anticipated that such noncompliance could occur, and provided the remedy (i.e., loss of federal funding). 42 U.S.C. § 1396c; *see also* 42 C.F.R. § 430.35.

These features set the present case apart from a "classic" preemption case, where a state seeks to exercise regulatory power in an area that Congress has taken exclusively for itself. Such true "conflicts" between state and federal law typically arise in cases concerning interstate commerce, international commerce, and foreign relations – those aspects of the national Union that the Framers sought to protect following unsatisfactory experiences under the Articles of Confederation. But a state's failure to satisfy a federal funding condition, as to a voluntary program in which it is not required to participate, does not frustrate the national purposes for which the Union was formed.

c. Finally, several different strands of prudential standing bar any claims that respondents may have. Because any right to hold the State to its Medicaid obligations under § 30(A) belongs to the federal government exclusively, respondents cannot satisfy the requirement that their lawsuits seek to vindicate rights personal *to them*. *See Warth v. Seldin*, 422 U.S. 490, 499 (1975). In addition, respondents do not "fall within 'the zone of interests to be protected or regulated by the statute or constitutional guarantee in question.'" *Valley Forge Christian College v. Americans United for Separation of Church & State*, 454 U.S. 464, 475 (1982). And lastly, the notion that providers may sue as "private enforcers" of "the proper constitutional structural relationship between the state and federal governments," *see Cal. Pharm.* Pet. App. 33, 39, 47-48, notwithstanding their lack of

any injury cognizable under § 30(A), cannot be reconciled with this Court's repeated rejection of such "generalized grievances" as a basis for private suits. *See Valley Forge*, 454 U.S. at 483-84.

ARGUMENT

I. PRIVATE PARTIES CANNOT ENFORCE § 30(A) BECAUSE CONGRESS HAS NOT CREATED A PRIVATE CAUSE OF ACTION TO ENFORCE THIS FEDERAL STATUTE

Respondents, who are private parties, seek to enforce a federal statute, § 30(A). Respondents concede, however, that Congress has not created a private cause of action to enforce § 30(A). Moreover, implying a private cause of action to enforce § 30(A) would conflict with congressional intent. Because respondents do not have a cause of action to enforce § 30(A), the Ninth Circuit's decisions in these cases should be reversed, and respondents' cases must be dismissed.

A. Only Congress Can Create a Private Cause of Action to Enforce a Federal Statute

As the entity that enacts federal statutes, Congress alone has the power to determine who may enforce them. "Like substantive federal law itself, private rights of action to enforce federal law must be created by Congress." *Alexander v. Sandoval*, 532

U.S. 275, 286 (2001); *see also Astra USA, Inc. v. Santa Clara County*, 131 S. Ct. 1342, 1347 (2011); *Horne v. Flores*, 129 S. Ct. 2579, 2598 n.6 (2009). Particularly when Spending Clause provisions are involved, clear evidence of congressional intent to create a private right of action is required: "[U]nless Congress 'speak[s] with a clear voice,' and manifests an 'unambiguous' intent to confer individual rights, federal funding provisions provide no basis for private enforcement." *Gonzaga Univ. v. Doe*, 536 U.S. 273, 280 (2002) (quoting *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1 (1981)). In these respects, private enforcement of federal statutes differs from private enforcement of *constitutional* obligations: "[T]he judiciary is clearly discernible as the primary means through which [constitutional] rights may be enforced." *Davis v. Passman*, 442 U.S. 228, 241 (1979).

The principle that Congress alone determines who may enforce federal statutes is grounded in separation of powers. "In the absence of congressional intent the Judiciary's recognition of an implied private right of action 'necessarily extends its authority to embrace a dispute Congress has not assigned it to resolve.'" *Stoneridge Inv. Partners, LLC v. Scientific-Atlanta*, 552 U.S. 148, 164-65 (2008) (quoting *Am. Fire & Casualty Co. v. Finn*, 341 U.S. 6, 17 (1951)). This Court has repeatedly reaffirmed this principle. *See, e.g., Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 508 n.9 (1990) ("Congress rather than the courts controls the availability of remedies for violations of statutes.");

Passman, 442 U.S. at 241 ("Statutory rights and obligations are established by Congress, and it is entirely appropriate for Congress, in creating these rights and obligations, to determine in addition, who may enforce them and in what manner.").

To ensure that private lawsuits to enforce federal statutes only proceed consistent with congressional intent, this Court has developed two separate tests that apply when (as here) Congress does not make its intentions express. Both tests require a congressionally-created, individualized "right" in favor of the plaintiff. First, a private cause of action may be implied from a federal statute if a plaintiff can demonstrate, *inter alia*, that the statute "create[s] a federal right in favor of the plaintiff"; there is "legislative intent . . . to create [but not] . . . deny" a private remedy; and implying a private remedy would be consistent with the "underlying purposes of the legislative scheme." *Cort v. Ash*, 422 U.S. 66, 78 (1975). Alternatively, a private cause of action may proceed under 42 U.S.C. § 1983 if a plaintiff can show that Congress has conferred an individual right on a private party; the right is not so "'vague and amorphous' that its enforcement would strain judicial competence"; and the provision is "'couched in mandatory, rather than precatory, terms.'" *Gonzaga*, 536 U.S. at 282. These tests ensure that private enforcement proceeds only as Congress intended, and avoid embroiling the judiciary in controversies that Congress has not assigned to it. *See Wilder*, 496 U.S. at 508 n.9 ("The [*Cort*] test reflects a concern, grounded

in separation of powers, that Congress rather than the courts controls the availability of remedies for violations of statutes."). In addition, these tests help ensure that federal courts do not become obliged to adjudicate issues for which judicial enforcement is not necessary or appropriate.

B. Section 30(A) Does Not Create a Private Cause of Action

It is undisputed that Congress did not confer any private rights when it enacted § 30(A), and therefore that Congress itself has not created a private cause of action to enforce this federal statute. The Ninth Circuit, itself, has held that § 30(A) does not contain any rights-creating language, and that the statute's text and structure reflect congressional intent that it be enforced administratively. *Sanchez v. Johnson*, 416 F.3d 1051, 1059-62 (9th Cir. 2005). In *Sanchez*, the Ninth Circuit explained that § 30(A) does not meet the criteria for private enforcement because, *inter alia*, the statute confers no "rights" on providers or beneficiaries, and is "ill-suited" for judicial enforcement because it incorporates "nebulous," "indeterminate[,] and competing" policy goals. *Id.* at 1059-60 ("The tension between these statutory objectives supports the conclusion that § 30(A) is concerned with overall methodology rather than conferring

individually enforceable rights on individual Medicaid recipients.").[6]

In the present cases, the Ninth Circuit did not purport to overrule *Sanchez*, but simply held that it is "inapposite" because respondents are suing under the Supremacy Clause instead of under § 1983. *Cal. Pharm.* Pet. App. 48; *see also Indep. Living* Pet. App. 87 ("[O]ur decision in [*Sanchez v.*] *Johnson* had nothing to say about a claim for injunctive relief brought under the Supremacy Clause."). The Ninth Circuit acknowledged that respondents are not seeking to enforce any statutory right, but held that rights are irrelevant in a Supremacy Clause cause of action. *Indep. Living Pet.* at 13 ("In this case . . . Independent Living does not seek direct enforcement

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[6] Virtually every other circuit to consider this issue since *Gonzaga* has reached the same conclusion. *Long Term Care Pharmacy Alliance v. Ferguson*, 362 F.3d 50, 57-58 (1st Cir. 2004); *N.Y. Ass'n of Homes & Servs. for the Aging, Inc. v. DeBuono*, 444 F.3d 147 (2d Cir. 2006) (per curiam); *Equal Access for El Paso, Inc. v. Hawkins*, 509 F.3d 697, 703-04 (5th Cir. 2007), *cert. denied*, 129 S. Ct. 34 (2008); *Westside Mothers v. Olszewski*, 454 F.3d 532, 542 (6th Cir. 2006); *Mandy R. ex rel. Mr. & Mrs. R. v. Owens*, 464 F.3d 1139, 1146-48 (10th Cir. 2006), *cert. denied*, 549 U.S. 1305 (2007); *see also Pa. Pharmacists Ass'n v. Houstoun*, 283 F.3d 531, 541-42 (3d Cir. 2002) (Alito, J.). The Eighth Circuit alone has reached a contrary result, although its decision recently was called into question. *Compare Pediatric Specialty Care, Inc. v. Ark. Dep't of Human Servs.*, 443 F.3d 1005, 1013-16 (8th Cir. 2006), *cert. granted, judgment vacated in part*, 551 U.S. 1142 (2007) (mem.) *with Minn. Pharmacists Ass'n v. Pawlenty*, No. 09-2723, 2010 U.S. Dist. LEXIS 11620 (D. Minn. Feb. 10, 2010).

of any 'rights' created by § 30(A)."); *Cal. Pharm.* Pet. at 32-33, 38-39, 46-48; *see also Indep. Living* Pet. at 87 (discussing *Sanchez*); *id.* at 92-93 ("They do not seek to enforce any substantive 'right' conferred by statute.").

Respondents have irrevocably conceded that § 30(A) does not confer any individual rights. Not a single respondent, in the seven appeals now consolidated before this Court, argued below that *Sanchez* was wrongly decided. To the very limited extent that they acknowledged *Sanchez* in their briefs, respondents dismissed it as "inapplicable and irrelevant." *See, e.g.*, Appellee's Answering Brief 10, No. 08-56422, Docket Entry No. 31 (9th Cir. Nov. 13, 2008) ("Hence the *Sanchez* rules which *are applicable only to § 1983 claims*, are inapplicable and irrelevant in the Supremacy Clause case at bar.").[7]

Because only Congress may create a right of action to enforce § 30(A), and because Congress did not do so here as respondents concede, respondents lack a cause of action. Congress has not spoken with a "clear voice" and manifested an "'unambiguous'

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[7] *See also* 9th Cir. No. 08-56422, Docket Entry No. 28, at 13-14; 9th Cir. No. 08-56422, Docket Entry No. 98, at 9-10; 9th Cir. No. 08-57016, Docket Entry No. 13, at 21-23; 9th Cir. No. 09-55532, Docket Entry No. 16, at 7; 9th Cir. No. 09-55532, Docket Entry No. 20, at 28 n.6; 9th Cir. No. 09-55365, Docket Entry No. 49, at 14-15; 9th Cir. No. 09-16359, Docket Entry No. 9, at 23 n.28 & 35-36; 9th Cir. No. 09-16359, Docket Entry No. 38, at 43-45; 9th Cir. No. 09-17633, Docket Entry No. 13, at 46.

intent to confer individual rights" under § 30(A), as required by *Gonzaga*, *Sandoval*, and *Cort*.

C. Implying a Cause of Action Would Contravene Congressional Intent

Not only would implying a cause of action contravene multiple lines of this Court's decisions requiring creation of a "right" before a private cause of action may proceed, to imply a cause of action here would frustrate specific congressional intent regarding the Medicaid Act. Congressional intent is paramount in a preemption context, no less than in any other context involving enforcement of federal statutes. *See Wyeth v. Levine*, 129 S. Ct. 1187, 1194 (2009) ("'[T]he purpose of Congress is the ultimate touchstone in every pre-emption case.'"). Congress's purposes include preserving and enhancing the States' flexibility to control and reduce costs and increase the efficiency of Medicaid; centralizing enforcement authority in HHS; and protecting the States from private lawsuits that drive up the cost of Medicaid. These purposes are reflected in the text and structure of § 30(A) and in the legislative history – purposes that are directly undermined by the Ninth Circuit's holdings here.

1. Implying a private cause of action to enforce § 30(A) is inconsistent with the statutory framework and, in particular, Congress's decision to centralize enforcement authority in HHS. *See Long Term Care Pharmacy Alliance*, 362 F.3d at 58; *Sanchez*, 416 F.3d

at 1059-61; *see also Astra*, 131 S. Ct. at 1349 (holding that private enforcement of obligations owed by pharmaceutical companies to the federal government under Medicaid's 340B program would undermine Congress's intent for centralized enforcement). Private suits undermine the key benefits of a centralized administrative enforcement scheme: national uniformity, consistency, and predictability in interpretation and administration of federal law. Indeed, states in the Ninth Circuit are now subject to onerous, judicially created requirements that apply nowhere else in the country.[8] This is the antithesis of how the system is supposed to work. *Gonzaga*, 536 U.S. at 292 (Breyer, J., concurring) (contrasting "the expertise, uniformity, wide-spread consultation, and resulting administrative guidance that can accompany agency decisionmaking" with the "comparative risk of inconsistent interpretations and misincentives that can arise out of an occasional inappropriate application of the statute in a private action for damages").

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[8] For example, the Ninth Circuit alone requires states to consider providers' costs in ratemaking, and to conduct a certain kind of pre-enactment "study" before reducing rates. *Compare Indep. Living* Pet. App. 10-12, 19-20, 55-56; *Cal. Pharm.* Pet. App. 3, 11-17, 36 *with Rite Aid of Pa., Inc. v. Houstoun*, 171 F.3d 842, 851-53 (3d Cir. 1999); *Minn. HomeCare Ass'n v. Gomez*, 108 F.3d 917, 918 (8th Cir. 1997) (per curiam); *Methodist Hosps., Inc. v. Sullivan*, 91 F.3d 1026, 1030 (7th Cir. 1996); *see also Pa. Pharmacists*, 283 F.3d at 538; *Evergreen Presbyterian Ministries Inc. v. Hood*, 235 F.3d 908, 933 n.33 (5th Cir. 2000), *overruled in part on other grounds, Equal Access for El Paso*, 509 F.3d at 704.

In addition, regulation by litigation makes it virtually impossible for states to plan and budget their Medicaid obligations. As the system is supposed to work, the States communicate regularly with CMS, even obtaining guidance memoranda as issues arise. Such communication reduces the likelihood that a state will guess incorrectly how CMS will interpret a Medicaid obligation and face substantial unplanned liabilities as a result. Litigation is far more unpredictable: California's failure to correctly predict how the Ninth Circuit would interpret § 30(A) has already cost its Medicaid program well over $1 billion in unanticipated expenses – exactly the result that the Court has explained should be avoided. *Pennhurst*, 451 U.S. at 16 ("[W]e may assume that Congress will not implicitly attempt to impose massive financial obligations on the States."); *see also Schlesinger v. Reservists Comm. to Stop the War*, 418 U.S. 208, 222 (1974) (cautioning against "government by injunction").

Private lawsuits also interfere with, and disrupt, CMS's own enforcement procedures. Again, this is vividly demonstrated in the present cases, where the injunctions have *materially altered and prejudiced* California's ability to obtain CMS approval of its still-pending SPAs. As this Court is already aware, in November 2010, CMS denied *all* of California's pending SPAs citing, *inter alia*, concern about the destabilizing effect on access to services if providers were required to repay funds issued pursuant to the pending injunctions. *See* Brief for the United States as

Amicus Curiae, App. 3a, *Independent Living*, S. Ct. No. 09-958 (filed Dec. 3, 2010) ("Additionally, CMS is concerned that, given the time that has elapsed since these SPAs were submitted, the cumulative effect of a retroactively effective approval of these reimbursement reductions would only serve to exacerbate access concerns."). These are issues that should be worked out between CMS and the States in the administrative process created by Congress, with participation by providers and beneficiaries in that process *as contemplated by HHS regulations*, and without the confounding impact of court injunctions. 42 C.F.R. §§ 430.76, 430.83, 430.86, 430.88.

2. The legislative history confirms that permitting private enforcement of § 30(A) would frustrate Congress's purposes. In enacting and amending § 30(A), Congress has repeatedly underscored that states must have substantial flexibility to innovate and run their Medicaid programs cost-effectively. Lawsuits are antithetical to that flexibility, as Congress made clear when it repealed a different provision (the Boren Amendment) that previously had been interpreted by the courts as a vehicle for bringing precisely the type of private challenges to Medicaid rates at issue here.

Section 30(A) was adopted in 1967 as a cost-saving measure, and required the States to include in their state plans methods and procedures to "safeguard against unnecessary utilization" of Medicaid services and to assure that payments to providers were not "in excess of reasonable charges consistent

with efficiency, economy, and quality of care." Social Security Amendments of 1967, Pub. L. No. 90-248, § 237(b), 81 Stat. 821, 911 (1968). In 1981, Congress deleted the "reasonable charges" requirement from § 30(A) in response to complaints that it hampered the States' abilities to innovate cost-effective approaches to provider reimbursement. *See* Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, § 2174, 95 Stat. 357, 809 (1981); H.R. Rep. No. 97-158, Pt. 2, at 312-33 (1981). Congress hoped that this and other amendments would "reduce Federal outlays in Medicaid . . . in a manner which . . . provides the States with flexibility to institute a number of measures in their programs to reduce cost and make them more efficient." H.R. Rep. No. 97-158, Pt. 2, at 279.[9] There is no suggestion in the legislative history of § 30(A) that Congress intended for private parties to enforce § 30(A), although there are numerous references to enforcement by HHS. *See, e.g.*, S. Rep. No. 90-744, at 28, 160 (1967), *reprinted in* 1967

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[9] Additional amendments to § 30(A) were made in 1972 and 1989. *See also* Social Security Amendments of 1972, Pub. L. No. 92-603, § 237(a)(2), 86 Stat. 1329, 1416 (1972) (requiring use of "utilization review plans" for some providers); Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6402(a), 103 Stat. 2106, 2260 (1989) (adding objective that payments be "sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area," as part of series of amendments intended to reduce infant mortality); H.R. Rep. No. 101-247, at 389-90 (1989), *reprinted in* 1989 U.S.C.C.A.N. 1906, 2115-16.

U.S.C.C.A.N. 2834, 2867, 3023; H.R. Rep. No. 101-247, at 390-91, *reprinted in* 1989 U.S.C.C.A.N. at 2116-17.

Congress's belief that private suits challenging the adequacy of Medicaid payments are antithetical to state flexibility is demonstrated by its repeal of the Boren Amendment following *Wilder v. Virginia Hospital Association*, 496 U.S. 498 (1990). The Boren Amendment required states to "find[] and make assurances satisfactory to the Secretary" that the Medicaid rates paid for skilled nursing facility and intermediate care facility services "are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities" to provide care in compliance with applicable state and federal law requirements. Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, § 962(a), 94 Stat. 2599 (1980). In *Wilder*, the Court held that the Boren Amendment conferred a "right" on providers, enforceable under § 1983, to "reimbursement rates that are reasonable and adequate to meet the costs of an efficiently and economically operated facility." 496 U.S. at 510. *Wilder* sparked a nationwide explosion of provider lawsuits challenging the adequacy of state Medicaid rates.[10]

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[10] *See, e.g.*, *Pinnacle Nursing Home v. Axelrod*, 928 F.2d 1306 (2d Cir. 1991); *Erie County Geriatric Ctr. v. Sullivan*, 952 F.2d 71 (3d Cir. 1991); *Temple Univ. v. White*, 941 F.2d 201 (3d Cir. 1991); *Abbeville General Hosp. v. Ramsey*, 3 F.3d 797 (5th Cir. 1993); *Ill. Health Care Ass'n v. Bradley*, 983 F.2d 1460 (7th

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Congress responded by repealing the Boren Amendment in 1997. Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4711, 111 Stat. 251, 507-08 (1997). In so doing, Congress repeatedly expressed its intent to eliminate private lawsuits in order to give the States more flexibility in setting Medicaid rates and to reduce Medicaid costs. A House committee report stated:

> A number of Federal courts have ruled that State systems failed to meet the test of "reasonableness" and some States have had to increase payments to these providers as a result of these judicial interpretations.[¶]. . . . It is the Committee's intention that, following enactment of this Act, *neither this nor any other provision of Section 1902* [of the Social Security Act, i.e., 42 U.S.C. § 1396a] will be interpreted as establishing a cause of action for hospitals and nursing facilities *relative to the adequacy of the rates they receive.*

H.R. Rep. No. 105-149, at 590-91 (1997) (emphasis added); *see also* 143 Cong. Rec. S6301-02, S6305 (1997) (statement of Sen. Domenici) ("Provide flexibility *instead of the rigidity brought on by lawsuits.* The Boren amendment should be dead." (emphasis added)). The Congressional Budget Office had estimated that Boren's repeal would reduce Medicaid spending

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Cir. 1993); *Kan. Health Care Ass'n, Inc. v. Kan. Dep't of Soc. & Rehab. Servs.*, 31 F.3d 1536 (10th Cir. 1994).

by about $1.2 billion from 1998 to 2002 – an estimate that "assumes that reimbursement rates for institutional providers would increase more slowly than if providers could *continue to use the threat of Boren suits as leverage against the states*." H.R. Rep. No. 105-149, at 625 (1997) (emphasis added).[11]

In short, by its repeal of Boren, Congress made clear that private lawsuits challenging the adequacy of rates impose an unacceptable burden on state flexibility. To paraphrase Senator Domenici, these types of lawsuits "should be dead." *See* 143 Cong. Rec. at S6305. The Ninth Circuit's effort to revive them must be rejected.

II. THE SUPREMACY CLAUSE DOES NOT PROVIDE A MECHANISM FOR CIRCUMVENTING *GONZAGA*, *SANDOVAL*, AND *CORT*

Respondents' position may be summarized succinctly: "[t]he claim that only Congress can create a right to sue to protect oneself against injury from

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[11] *See also* 143 Cong. Rec. at S6305 (statement of Sen. Gramm) ("The Boren amendment has produced endless lawsuits. States want to negotiate with hospitals and get the best rate they can. Repealing the Boren amendment takes it out of the courts."); 143 Cong. Rec. S6058-04, S6068 (1997) (statement of Sen. Roth) (repeal of Boren Amendment "will take the providers and the States out of the Federal courts and put them back at the contract negotiating table"); 142 Cong. Rec. S5305-05, S5355 (1996) (statement of Sen. Chafee) (repeal "will allow States to establish their own reimbursement rates and free them from much of the litigation that now exists").

preempted state action, is hookum [sic] and bunkum." Appellee's Answering Brief 9, No. 08-56422, Docket Entry No. 31 (9th Cir. Nov. 13, 2008). According to respondents, the Constitution *always* creates a cause of action to enforce a federal statute when it allegedly conflicts with state law, and "Congressional intent is not relevant" as to whether such a cause of action exists. Brief in Opposition 13, *Maxwell-Jolly v. Santa Rosa Memorial Hospital*, No. 10-283 (filed Oct. 27, 2010). Respondents squarely reject, therefore, the proposition that Congress alone determines who may enforce federal statutes; and they reject the proposition that congressional intent is even relevant, much less *dispositive*, on whether statutes may be privately enforced.

Respondents are wrong. As this Court recently explained in *Astra*, another case involving private parties' efforts to enforce Medicaid obligations owed to the federal government in the absence of a right to sue: "[t]he absence of a private right to enforce the statutory . . . obligations would be rendered meaningless if [private parties] could overcome that obstacle by" simply recasting the theory under which their claims are brought. *Astra*, 131 S. Ct. at 1348. Respondents' suits to enforce § 30(A), whether characterized as § 1983 claims or preemption claims, "are in substance one and the same" and "[t]heir treatment, therefore, must be the same, '[n]o matter the clothing in which [private parties] dress their claims.'" *Id.* at 1345 (quoting *Tenet v. Doe*, 544 U.S. 1, 8 (2005)). The Court should reject respondents' invocation of the

Supremacy Clause to effectuate an end run around *Gonzaga* and *Cort*.

A. The Supremacy Clause Provides a Rule of Decision Rather than a Cause of Action

1. The Supremacy Clause cannot, on its own, supply respondents with a cause of action. This Court has repeatedly held that the Supremacy Clause is not a "source of any federal rights." *Golden State Transit Corp. v. City of Los Angeles*, 493 U.S. 103, 107 (1989); *Chapman v. Houston Welfare Rights Org.*, 441 U.S. 600, 613 & n.29 (1979); *see also Dennis v. Higgins*, 498 U.S. 439, 450 (1991). Thus, the Court has contrasted the Supremacy Clause, which is "'not a source of any federal rights,'" with the Commerce Clause, which "of its own force imposes limitations on state regulation of commerce and is the source of a right of action in those injured by regulations that exceed such limitations." *Dennis*, 498 U.S. at 450. And the Court repeatedly has rejected use of the Supremacy Clause to constitutionalize claims that are fundamentally statutory. *Golden State*, 493 U.S. at 107; *Chapman*, 441 U.S. at 615; *Swift & Co. v. Wickham*, 382 U.S. 111, 126 (1965) (Supremacy Clause was not a "substantive provision of the Constitution" requiring a three-judge court, under a statute requiring such a panel to restrain enforcement of a state statute "upon the ground of the unconstitutionality of such statute"). Of course, that is exactly what respondents are seeking to do in the present case: to constitutionalize,

via the Supremacy Clause, a claim that a state allegedly is not complying with § 30(A).

Instead, the Supremacy Clause operates to supply a rule of decision for parties who are properly before the court. *Chapman*, 441 U.S. at 613 (while the Supremacy Clause "is not a source of any federal rights, it does 'secure' federal rights by according them priority whenever they come in conflict with state law"); *Swift*, 382 U.S. at 120 ("[I]f a state measure conflicts with a federal requirement, the state provision must give way."); *Wilderness Soc'y v. Kane County*, 581 F.3d 1198, 1234 (2009) (McConnell, J., dissenting) ("The Supremacy Clause is not an independent source of rights but a rule of priority that determines who wins when state and federal law conflict."), *on reh'g en banc*, 632 F.3d 1162 (10th Cir. 2011); *see also* Viet D. Dinh, *Reassessing the Law of Preemption*, 88 Geo. L.J. 2085, 2088 (2000) ("[T]he Supremacy Clause . . . prescribed a constitutional choice of law rule, one that gives federal law precedence over conflicting law."); Caleb Nelson, *Preemption*, 86 Va. L. Rev. 225, 250 (2000) (similar).

2. This understanding of the Supremacy Clause follows from the circumstances of its adoption. Under the Framers' conception, the Supremacy Clause was not intended to confer any substantive rights or powers on Congress, private parties, or anyone else. Rather, it was adopted to eliminate an ambiguity that persisted, under the Articles of Confederation and then contemporary choice-of-law rules, regarding

what law courts should apply when faced with a conflict between state and federal law.

The Supremacy Clause, like the Constitution as a whole, emerged from dissatisfaction with the Articles of Confederation, and particularly the new government's inability to bind the States in matters affecting interstate commerce, domestic security, and foreign relations. Perceived weaknesses under the Articles included lack of state compliance with the Treaty of the Peace in the aftermath of the Revolution; conflicts between states with respect to navigable waters; and other forms of commercial protectionism from which "the national dignity, interest, and revenue, [have] suffered." James Madison, Vices of the Political System of the United States (1787), *in* 2 *The Writings of James Madison* 362-63 (G. Hunt ed., 1901); *see also The Federalist* No. 22, at 107-08, 113 (I. Shapiro ed., 2009) (Alexander Hamilton); *The Federalist* No. 42, at 216 (James Madison); Records of the Federal Convention, *in* 4 *The Founders' Constitution* 593 (Kurland ed., 1987) (statement of Mr. Wilson); *see generally* Christopher R. Drahozal, *The Supremacy Clause* 4-11 (2004).

One concern was whether state judges would apply federal or state law when they were in conflict, given the traditional presumption of implied repeals:

> Whenever a law of a State happens to be repugnant to an act of Congress, particularly when the latter . . . is of posterior date to the former, . . . it will be at least questionable whether the latter . . . must not prevail; and

> as the question must be decided by the Tribunals of the State, they will be most likely to lean on the side of the State.

Madison, Vices of the Political System of the United States, *supra*, at 364-65; *see also The Federalist* No. 78, at 394 (Alexander Hamilton) (duty of judges faced with conflicting laws to harmonize them or, if that is not possible, "the last in order of time shall be preferred").

To address this last question, the delegates to the Constitutional Convention considered several options, including: "1. a Veto on the passage of the State laws. 2. a Congressional repeal of them, 3. a Judicial annulment of them." Letter from James Madison to N. P. Trist (Dec. 1831), *in* 3 *The Records of the Federal Convention of 1787*, at 516 (Farrand ed., 1937). James Madison and Charles Pinkney, among others, proposed to give Congress the "power of negativing" conflicting state laws after they were enacted. *See* Records of the Federal Convention, *in* 4 *The Founders' Constitution*, *supra*, at 592-96. Opponents of the "negativing" power were concerned about its potential for abuse, or thought it "unnecessary, as the Courts of the State would not consider as valid any law contravening the Authority of the Union, and which the legislature would wish to be negatived." *Id.* at 593-95. Proponents did not want to depend on the "firmness of Judges," and therefore believed that "[i]t will be better to prevent the passage of an improper law, than to declare it void when passed." *Id.* at 596 (statement of Mr. Wilson). Nonetheless, the delegates ultimately rejected conferring a "negativing" power on Congress in favor of the declaration of "supremacy"

now found in Article VI. *Id.* at 596; *see also The Federalist* No. 80, at 401 (Alexander Hamilton); *see generally* Drahozal, *supra*, 12-25.

The Framers understood that a declaration of Supremacy would change the normal rules of construction. Alexander Hamilton explained that, where statutes conflict of "an EQUAL authority," the later-in-time will prevail under existing rules of construction applied by the courts. *The Federalist* No. 78, at 394 (Alexander Hamilton). However, a "prior act of the superior [authority] ought to be preferred to the subsequent act of an inferior and subordinate authority." *Id.* at 394-95. "[A]ccordingly, whenever a particular statute contravenes the Constitution, it will be the duty of the judicial tribunals to adhere to the latter and disregard the former." *Id.* at 395; *see also The Federalist* No. 80, at 401 (Alexander Hamilton) (Convention rejected the "direct negative on State laws" in favor of "an authority of the federal courts to overrule such as might be in manifest contravention of the articles of Union").

During the debates preceding ratification, the Framers took pains to explain that this was *all* that the Supremacy Clause would accomplish. "[I]t may be affirmed with perfect confidence that the constitutional operation of the intended government *would be precisely the same*, if [the Necessary and Proper Clause and the Supremacy Clause] were entirely obliterated. . . . They are *only declaratory of a truth* which would have resulted by necessary and unavoidable implication from the very act of constituting

a federal government, and vesting it with certain specified powers." *The Federalist* No. 33, at 159 (Alexander Hamilton) (emphasis added); *see also id.* at 161 ("[T]he clause which declares the supremacy of the laws of the Union . . . only declares a truth, which flows immediately and necessarily from the institution of a federal government."). Writing after the fact, Joseph Story explained that the Supremacy Clause, and particularly its concluding words ("any thing in the constitution or laws of any state to the contrary notwithstanding"), were "introduced from abundant caution, to make its obligation more strongly felt by the state judges." 3 Joseph Story, *Commentaries on the Constitution of the United States*, § 1833, at 697 (Fred B. Rothman & Co. 1991) (1833); *see also id.*, § 1836, at 701 ("From this supremacy of the constitution and laws and treaties of the United States, within their constitutional scope, arises the duty of courts of justice to declare any unconstitutional law passed by congress or by a state legislature void.").

The placement of the Supremacy Clause in Article VI (rather than in Article I, section 8) of the Constitution confirms the proper understanding of the Clause as a choice-of-law provision rather than a substantive source of rights. "On its face, the Supremacy Clause only prescribed a constitutional choice of law rule, one that gives federal law precedence over conflicting law. If the Clause were meant to be an affirmative grant of Congressional power, it would likely reside in the metropolis of Congressional

power, Article I, Section 8 . . . rather than in the suburbs of Article VI." Dinh, *supra*, at 2088.

3. *Ex parte Young*, 209 U.S. 123 (1908), did not change this understanding of the Supremacy Clause. This Court did not purport to create, in *Ex parte Young*, a new, standalone, private cause of action to enforce federal statutes, but only described an "exception" to the States' immunity under the Eleventh Amendment where a party sues a state official to enjoin a state enforcement action. *See Va. Office for Protection & Advocacy v. Stewart*, 131 S. Ct. 1632, 1638 (2011). An exception to immunity is the nonexistence of a defense, not a cause of action. Moreover, "[t]he Court wields *Young* in the name of the Supremacy Clause only to vindicate important federal rights." *Va. Office for Protection & Advocacy*, 131 S. Ct. at 1644 (Kennedy, J., concurring); *accord*, *id.* at 1638 (quoting *Pennhurst State Sch. & Hosp. v. Halderman*, 465 U.S. 89, 105 (1984)). Here, there is no federal right to vindicate.

4. Confronted with a correct reading of the Supremacy Clause, respondents note that this Court often has issued preemption decisions without first analyzing whether any congressionally conferred right existed. The lack of discussion of "rights" in the case law does not mean that such "rights" did not exist, but may simply be a vestige of an "*ancien régime*," in which "rights" were not analyzed with the rigor with which they are today. *See Sandoval*, 532 U.S. at 287; *Gonzaga*, 536 U.S. at 283. Where the rights issue *has* been raised, so far as petitioners can

determine, this Court has never held that a private cause of action exists to enforce a federal statute that all parties concede does not satisfy the requirements for private enforcement set forth in *Gonzaga* and *Cort*.

This Court's preemption cases generally fall into two, somewhat overlapping, categories, both of which are consistent with *Sandoval* and *Gonzaga*, and neither of which involves the type of rights-less, standalone cause of action at issue here. The first category consists of preemption cases in which the Court expressly found, or assumed, the existence of an individually enforceable federal right. *See, e.g.*, *Golden State Transit*, 493 U.S. at 109 (holding that preempting federal statute, "the NLRA[,] gives . . . rights enforceable against governmental interference"); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96 n.14 (1983) ("It is beyond dispute that federal courts have jurisdiction over suits to enjoin state officials from *interfering with federal rights*." (emphasis added)); *Gibbons v. Ogden*, 9 Wheat. 1, 210 (1824) (under the Supremacy Clause, courts determine "validity" of state law that "come[s] into collision with an act of Congress, and deprive[s] a citizen *of a right* to which that act entitles him" (emphasis added)). In addition, in some cases, although individual rights were not expressly identified as such, they likely existed. *See, e.g., Arkansas Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S. 268, 283 (2006) (enforcing anti-lien provision of Medicaid Act, 42 U.S.C. § 1396p, mandating that "[n]o lien may be imposed against the

property of any individual prior to his death on account of medical assistance paid or to be paid on his behalf under the State plan").[12] The present cases do not fall into this category as they involve no substantive federal right, whether implied, express, or assumed.

The second category includes cases in which preemption is asserted as a defense, rather than as a standalone cause of action. Such defenses are raised in one of two ways: either (1) the party is a defendant in a civil proceeding, such as a tort case or a local enforcement action, and the party raises preemption as an affirmative defense to liability in that case;[13] or (2) the party is a plaintiff in a lawsuit filed to forestall future state (or local) enforcement of state (or local) regulation of the party's conduct, and the party asserts a preemption defense on an anticipatory basis before such enforcement has occurred.[14] Such cases

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[12] In addition, a number of this Court's preemption cases involved statutes expressly preempting state law or prohibiting state regulation, statutory language that may supply the congressional intent needed to support an implied right of action. *See, e.g., Cuomo v. Clearing House Ass'n, L.L.C.*, 129 S. Ct. 2710 (2009) (NBA); *Rowe v. N.H. Motor Transp. Ass'n*, 552 U.S. 364 (2008) (FAAAA); *Watters v. Wachovia*, 550 U.S. 1 (2007) (NBA); *Bates v. Dow Agrosciences*, 544 U.S. 431 (2005) (FIFRA); *Engine Mfrs. Ass'n v. South Coast Air Quality*, 541 U.S. 246 (2004) (CAA); *Shaw*, 463 U.S. 85 (ERISA).

[13] *See, e.g., CSX Transp., Inc. v. Easterwood*, 507 U.S. 658 (1993).

[14] *See, e.g., Cuomo*, 129 S. Ct. 2710; *Chamber of Commerce of the United States v. Brown*, 128 S. Ct. 2408 (2008); *Rowe*, 552

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are easily harmonized with *Sandoval* and *Gonzaga* because they do not involve a standalone cause of action to enforce federal law, but instead involve preemption solely as a defense to state regulation of a defendant's (or putative defendant's) conduct. *See Wilderness Soc'y*, 581 F.3d at 1233 (McConnell, J., dissenting) (availability of preemption "defense" to state enforcement proceedings does not mean that anyone "can bring a freestanding preemption claim to enforce compliance with federal law, as if 'preemption' were a cause of action"). The present cases do not fall into this category, either: Medicaid beneficiaries and providers are not raising preemption as a defense to regulation of their conduct, but rather as a standalone cause of action to force the State to take affirmative action in order to conform the State's conduct with respondents' notions of what federal law requires.[15]

U.S. 364; *Watters*, 550 U.S. 1; *Engine Mfrs.*, 541 U.S. 246. Such cases typically are brought as declaratory judgment actions. In addition, a private cause of action may exist for the specific purpose of enjoining anticipated state enforcement proceedings. *See Va. Office for Protection & Advocacy*, 131 S. Ct. at 1642 (Kennedy, J., concurring); *Golden State*, 493 U.S. at 113, 119 (Kennedy, J., concurring); John Harrison, *Ex parte Young*, 60 Stan. L. Rev. 989, 997 (2008) (discussing bill in equity to "restrain proceedings at law"), *cited with approval*, 131 S. Ct. at 1642 (Kennedy, J., concurring).

[15] To the two categories of preemption cases identified above may be added a third: the federal government may sue to enjoin state law that purportedly is preempted by federal law. *See, e.g., Cuomo*, 129 S. Ct. at 2714; *see also Verizon Md., Inc. v. Public*

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Thus, the Ninth Circuit's creation of a standalone Supremacy Clause cause of action cannot be reconciled with the Constitution's structure or history, or with this Court's precedent. The Ninth Circuit's cause of action bears no resemblance whatsoever to the Framers' conception of the Supremacy Clause as a rule of construction to support nullification of state law as necessary to protect federal rights. Instead, the Ninth Circuit used the Supremacy Clause to create a cause of action that Congress itself declined to create, complete with retroactive damages *and* injunctive relief. *See Indep. Living* Pet. App. 29-37 (reversing district court's order to extent that it ordered purely prospective relief, and authorizing retroactive relief as well); *id.* at 46-47 ("Independent Living was entitled to money damages for the Director's past conduct.").[16] Because no such cause of action exists, the decisions at issue must be reversed.

Serv. Comm'n, 535 U.S. 635, 640-41 (2002) (federal government intervened in private lawsuit and filed petition for certiorari).

[16] Although the Ninth Circuit rejected the proposition that retroactive damages were barred by the State's immunity (a holding that California disputes but does not challenge at this time), the court never addressed the entirely separate question of the source of a court's authority to award money damages in a preemption case. There is none.

B. Cases Involving Spending Clause Legislation are Particularly Inappropriate for the Supremacy Clause

Moreover, Spending Clause legislation is a particularly inappropriate context for raising up standalone causes of action that Congress declined to create. Principles of supremacy, and of preemption generally, have no application to allegations that a state has failed to satisfy a federal funding condition.

The relationship between the federal and state governments with respect to Spending Clause legislation such as the Medicaid Act is defined not by the supremacy of federal law, but by the terms of the quasi-contractual agreement between the state and federal governments. *See Pennhurst*, 451 U.S. at 17; *see also Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy*, 548 U.S. 291, 296 (2006). Through the Spending Clause, Congress may entice the States to accept obligations that it may not directly mandate. *N.Y. v. United States*, 505 U.S. 144, 166-67 (1992). Thus, in the Spending Clause context, it is a state's voluntary agreement to be bound, rather than the inherent supremacy of federal law, that obligates a state to comply with any federal requirements.[17]

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[17] Congress *could* have included within that agreement a right for private parties to enforce § 30(A), as it has done for other provisions of the Medicaid Act, but it did not do so. *See, e.g., Doe v. Kidd*, 501 F.3d 348 (4th Cir. 2007) ("reasonable promptness" and "freedom of choice," 42 U.S.C. §§ 1396a(a)(8), (a)(23)), *cert. denied*, 522 U.S. 1243 (2008); *Harris v. Olszewski*, 442 F.3d

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The remedy for any noncompliance with respect to the Medicaid Act, therefore, is supplied not by the Supremacy Clause, but by the terms of the State's contract with the federal government. And that remedy is clearly and unambiguously set forth in a statute: the Secretary of HHS is authorized to withhold federal financial participation in cases of noncompliance. *See* 42 U.S.C. § 1396c; *see also* 42 C.F.R. § 430.35. Indeed, the Medicaid Act and its implementing regulations anticipate that instances of noncompliance may arise. And they expressly contemplate repayment of disallowed funds rather than negation of the State's action (assuming the State does not opt voluntarily to comply). *See* 42 C.F.R. §§ 430.33(c)(3), 430.35(d), 430.42(a),(d), 430.48.

The Supremacy Clause cannot be used to "invalidate" or declare "null and void" a state's Medicaid payments, because a state is free to retain its (purportedly noncomplying) payment scheme. In enacting Medicaid, Congress did not strip the States of their power to regulate, but merely imposed conditions for

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456 (6th Cir. 2006) ("freedom of choice," 42 U.S.C. § 1396a(a)(23)); *Watson v. Weeks*, 436 F.3d 1152 (9th Cir. 2006) ("making medical assistance available," 42 U.S.C. § 1396a(a)(10)); *S.D. ex rel. Dickson v. Hood*, 391 F.3d 581 (5th Cir. 2004) (EPSDT services for recipients under the age of twenty-one, 42 U.S.C. §§ 1396a(a)(10)(A), 1396d(a), 1396d(r)(5)); *Beeker v. Olszewski*, 415 F. Supp. 2d 734 (E.D. Mich. 2006) (no denial of service based on inability to pay, 42 U.S.C. § 1396o(e)); *Meachem v. Wing*, 77 F. Supp. 2d 431 (S.D.N.Y. 1999) (fair hearings, 42 U.S.C. § 1396a(a)(3)).

the receipt of federal funds. Consistent with the voluntary nature of the Spending Clause contract, if a state fails to comply with federal Medicaid law, the state faces a choice: it can either continue to apply its law (and face federal enforcement), or it can bring its action into compliance with federal law. *See Pennhurst*, 451 U.S. at 28-30 & n.23. Simply put, if a state fails to comply with a federal condition for receiving federal funding, the state is not in "conflict" with federal law, as Congress expressly anticipated that such noncompliance could occur, and provided the remedy. 42 U.S.C. § 1396c.

Respondents thus seek to apply the Supremacy Clause where it does not belong. As discussed *supra* Part II.A, the Supremacy Clause was adopted to protect Congress's exercise of power particularly with respect to commerce and treaties – areas in which Congress may exercise exclusive regulatory (i.e., preempting) authority. *See Gibbons*, 9 Wheat. at 199-200 ("[W]hen a State proceeds to regulate commerce with foreign nations, or among the several States, it is exercising the very power that is granted to Congress, and is doing the very thing which Congress is authorized to do."). State economic regulations that affect interstate or international commerce may raise special concerns – i.e., the potential to frustrate the national purposes for which the Union was formed – that justify less judicial deference than other forms of state action. By contrast, a state's purported failure to satisfy a voluntary federal funding condition, and the risk that it may forfeit federal funding as a result,

does not frustrate the national purposes for which the Union was formed.[18]

C. Respondents Cannot Overcome Prudential Standing Limitations to Assert Any Claims They May Have

Even if respondents somehow could identify a vehicle for their arguments, their claims would be barred by three separate strands of prudential standing jurisprudence. Prudential standing "embodies 'judicially self-imposed limits on the exercise of federal jurisdiction.'" *Elk Grove Unified Sch. Dist. v. Newdow*, 542 U.S. 1, 11 (2004) (citations omitted). Like the requirements for private lawsuits set forth in *Cort* and *Gonzaga*, prudential standing principles protect the judiciary from becoming embroiled in issues and disputes that properly belong to another branch. *Warth*, 422 U.S. at 500; *Valley Forge Christian*

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[18] Put another way, the Framers anticipated that the Supremacy Clause would operate to prevent state interference with Congress's exercise of its *enumerated powers under the Constitution*. *The Federalist* No. 33, at 161 ("It will not, I presume, have escaped observation, that it *expressly* confines this supremacy to laws made *pursuant to the Constitution*") (Alexander Hamilton); *see also* Story, *supra*, § 1831, at 694 ("It will be observed, that the supremacy of the laws is attached to those only, which are made in pursuance of the constitution."). No one has alleged that California has prevented the exercise of, or otherwise interfered with, Congress's authority under the Spending Clause. Congress remains free to spend – or withhold – its money on the Medicaid program, notwithstanding any purported violation by a state of a funding condition.

College v. Americans United for Separation of Church & State, 454 U.S. 464, 474 (1982). Although the Ninth Circuit did not reach these issues overtly, in three separate decisions in the *California Pharmacists* appeals, the court expressly rejected the proposition that *anything* more than Article III standing is required to assert a Supremacy Clause claim. *Cal. Pharm.* Pet. App. 46 (a plaintiff pursuing a Supremacy Clause Claim does not need a federally created "right," "but *need only satisfy traditional standing requirements*" (emphasis added)); *see also id.* 32-33, 38-39.[19] This is because, the court explained, "the cause of action is one to enforce the proper constitutional structural relationship between the state and federal governments and therefore is not rights based." *Cal. Pharm.* Pet. App. 47; *see also id.* 32-33, 38-39. Rather, according to the Ninth Circuit, anyone can act as a "private enforcer[] of the Supremacy Clause," irrespective of their "specific relationship" to the federal statute at issue. *Cal. Pharm.* Pet. App. 48.

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[19] Citing *Warth v. Seldin*, DHCS argued in two appeals (*California Pharmacists* and *Independent Living IV*) in the Ninth Circuit that prudential standing principles barred respondents' claims because they did not assert any "rights" of their own. Defendant-Appellant David Maxwell-Jolly's Opening Brief 30-33, No. 09-55692, Docket Entry No. 12 (9th Cir. June 19, 2009); Defendant-Appellant's Opening Brief 22 n.10, No. 09-55532, Docket Entry No. 11 (9th Cir. May 19, 2009). In *Santa Rosa*, DHCS asserted that providers' claims are barred by the zone-of-interest component of prudential standing. Appellant's Opening Brief 36, No. 09-17633, Docket Entry No. 6 (9th Cir. Dec. 17, 2009).

The same defects that doom respondents' claims under *Cort* and *Gonzaga* also bar their claims under prudential standing principles.

First, respondents cannot satisfy the requirement that their lawsuits seek to vindicate their own rights, rather than those belonging to a third party. *See Warth*, 422 U.S. at 499 (prohibition against "rest[ing] [a] claim to relief on the legal rights or interests of third parties"). Here, lacking any legally enforceable right themselves, respondents seek instead to enforce the undisputed right of a third party – the United States government – to hold California to its Medicaid obligations. But the federal government is the best proponent of its own rights. 42 U.S.C. § 1396c; *Singleton v. Wulff*, 428 U.S. 106, 114 (1976). Respondents' attempt to enforce an obligation owed not to them, but to the federal government, thus runs directly afoul of the prohibition against resting a claim entirely on the rights of third parties. *See, e.g., Wilderness Soc'y*, 632 F.3d at 1170-72 (prudential standing principles barred lawsuit by environmental organizations seeking to enforce the federal government's property rights).

Second, the providers' claims do not "fall within 'the zone of interests to be protected or regulated by the statute or constitutional guarantee in question.'" *Valley Forge*, 454 U.S. at 475; *see also Bennett*, 520

U.S. at 163.[20] There is no indication that Congress intended § 30(A) to protect providers' interests in Medicaid rate-setting. *See Sanchez*, 416 F.3d at 1059-60; *see also supra* Part I.C (discussing congressional intent to preclude suits). Accordingly, their claims are barred on this independent basis.

Third, the Ninth Circuit's conception of Medicaid providers as "private enforces of the Supremacy Clause" runs afoul of the prohibition against private lawsuits premised on "generalized grievances." A claim to "enforce the proper structural constitutional relationship between the state and federal governments," *Cal. Pharm.* Pet. App. 47, which is devoid of any judicially cognizable injury, is an archetypal generalized grievance. *See Valley Forge*, 454 U.S. at 483-84 ("This Court repeatedly has rejected claims of standing predicated on '"the right, possessed by every citizen, to require that the Government be administered according to law."'"); *see also Warth*, 422 U.S. at 499-500; *Schlesinger*, 418 U.S. at 223-25.

* * *

California's Medicaid program has lost over a billion dollars since the Ninth Circuit first recognized a Supremacy Clause cause of action to enforce § 30(A)

---

[20] Medicaid beneficiaries also do not fall within the "zone of interests" that § 30(A) was designed to protect, as the statute is concerned with ratemaking in the aggregate rather than with the rights of beneficiaries. *See Sanchez*, 416 F.3d at 1059-60. However, DHCS did not make this argument below.

in *Independent Living I*, and California is losing tens of millions more each month that injunctions issued pursuant to that authority remain in place. In addition to costing California enormous sums of mōney, the lawsuits have interfered with the centralized administrative enforcement process created by Congress for holding the States to their Medicaid obligations. None of these injunctions should ever have issued, because these disputes belong not in the courts but before HHS, as Congress intended. The Court should reject respondents' efforts to invoke the Supremacy Clause to effectuate an end-run around congressional intent and this Court's decisions in *Gonzaga*, *Sandoval*, and *Cort*. And it should clarify that any remedy for a state's purported breach of a funding condition must be provided by Congress, through the legislation it enacts, rather than by the Constitution.

CONCLUSION

For the foregoing reasons, the judgments below should be reversed.

Dated: May 19, 2011

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RECORD
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Nos. 09-958, 09-1158, 10-283

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In The
Supreme Court of the United States

TOBY DOUGLAS, DIRECTOR OF THE DEPARTMENT OF HEALTH CARE SERVICES, STATE OF CALIFORNIA, PETITIONER,

v.

INDEPENDENT LIVING CENTER OF SOUTHERN CALIFORNIA, INC., ET AL.

TOBY DOUGLAS, DIRECTOR OF THE DEPARTMENT OF HEALTH CARE SERVICES, STATE OF CALIFORNIA, ET AL., PETITIONERS,

v.

CALIFORNIA PHARMACISTS ASSOCIATION, ET AL.

TOBY DOUGLAS, DIRECTOR OF THE DEPARTMENT OF HEALTH CARE SERVICES, STATE OF CALIFORNIA, PETITIONER,

v.

SANTA ROSA MEMORIAL HOSPITAL, ET AL.

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF OF INTERVENOR RESPONDENTS IN NO. 09-958 AND *CALIFORNIA PHARMACISTS* RESPONDENTS IN NO. 09-1158

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QUESTION PRESENTED

Whether persons harmed by a state law may maintain an action in federal court to enjoin state officials from enforcing that law on the ground that it is preempted under the Supremacy Clause by federal law, namely 42 U.S.C. § 1396a(a)(30)(A).

CORPORATE DISCLOSURE

The non-individual respondents who file this brief have no parent corporations and no publicly held company owns any stock in these respondents.

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INTRODUCTION

Respondents established that they would experience immediate irreparable injury to their health and finances if petitioners, California state officials, were permitted to implement a state law requiring draconian cuts to the rates the state officials were paying medical service providers to provide health care to poor and disabled Californians.[1] The case comes to this Court on the premise—found by the courts below and not on review here—that the state law petitioners sought to implement conflicted with federal law, namely 42 U.S.C. § 1396a(a)(30)(A) (Section 30(A)).

Respondents sought and obtained injunctions from a federal court to stop these officials from implementing the state law that was preempted under the Supremacy Clause. This action is authorized by a

---

[1] The intervenor respondents in No. 09-958 are the Sacramento Family Medical Clinics, Inc.; Theodore Mazer, M.D.; Ronald B. Mead, D.D.S.; and Acacia Adult Day Services. The plaintiffs in the so-called *California Pharmacists* action of No. 09-1158 are the California Hospital Association; California Association for Adult Day Services; Acacia Adult Day Services; Sharp Memorial Hospital; Grossmont Hospital Corporation; Sharp Chula Vista Medical Center; Sharp Coronado Hospital and Healthcare Center; Fe Garcia; Charles Gallagher; the California Pharmacists Association; California Medical Association; California Dental Association; South Sacramento Pharmacy; Farmacia Remedios, Inc.; and Marin Apothecary, Inc. d/b/a Ross Valley Pharmacy. As petitioners acknowledge (Pet. Br. iii n.1), the last six plaintiffs listed were named in the No. 09-1158 petition but were not parties in the court of appeals and thus are not respondents.

host of this Court's decisions, including such notable ones as *Osborn v. Bank of the United States*, 22 U.S. 738 (1824), and *Ex parte Young*, 209 U.S. 123 (1908).

Petitioners and the United States each start their briefs with extensive arguments that Section 30(A) does not confer a "right" as that term has been interpreted for purposes of 42 U.S.C. § 1983. But whether there is such a Section 1983 "right" under Section 30(A) does not answer the question at issue here: whether respondents can seek relief in federal court to enjoin conduct by state officials that is preempted under the Supremacy Clause by federal law.

As to that question, there is no dispute by petitioners or their amici that, apart from Section 1983, this Court repeatedly has acknowledged and acted on its power to hear such claims. It is this cause of action that is the basis for these suits. Nothing in Section 1983 or its jurisprudence overrules or limits this other avenue of relief. Section 1983 serves a different purpose and provides different remedies.

The absence of the injunctive remedy sought here would severely undermine the Supremacy Clause and the liberty promoted by our federalism. This is particularly true in a case such as this where, even following federal agency disapproval of the rate cuts, the relevant federal agency has not successfully stopped petitioners from continued implementation of those cuts. Instead, those lower rates remain in

effect except to the extent barred by the federal court injunctions at issue here.

STATEMENT

A. Statutory Framework

1. Title XIX of the Social Security Act, 42 U.S.C. § 1396 *et seq.* (Medicaid Act), is a cooperative federal-state program that provides federal financial assistance to participating States to enable them to provide medical treatment for the poor, elderly, and disabled.

To receive federal funds, States are required to establish and administer their Medicaid programs through individual "State plans for medical assistance" approved by the federal Secretary of Health and Human Services (HHS). 42 U.S.C. § 1396a(a). The State must comply with the approved plan until it either withdraws from the program or HHS approves an amendment to the state plan. 42 C.F.R. § 430.20(b)(2).

When a state plan amendment is submitted to HHS, HHS has 90 days to make a determination whether the amendment complies with the Medicaid Act. 42 U.S.C. § 1396n(f)(2). If HHS does not act within this time frame, the state plan amendment is considered approved. *Ibid.* If however, HHS asks for more information from the State, HHS has a second 90-day time frame, beginning on the date the requested information is received from the State. *Ibid.*

The Medicaid Act provides specific requirements for state plans and reimbursement rates. Section 30(A), the provision at issue in this case, provides that a state plan

> must * * * provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan * * * as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

42 U.S.C. § 1396a(a)(30)(A).

B. California's Challenged Conduct

1. California law authorizes the State to apply for federal financial assistance in Medicaid through a state program called Medi-Cal. *See* Cal. Welf. & Inst. Code §§ 14000.3, 14000.4, 14020. Medical service providers who participate in Medi-Cal must accept the Medi-Cal payment as payment-in-full, and will be subject to penalties if they require that patients pay anything beyond that amount. *See* Cal. Welf. & Inst. Code § 14019.4(a) & (c).

Before the various legislation leading to these civil actions, Medi-Cal payments per enrollee were

the nation's lowest for all enrollees. The Kaiser Family Foundation, *Medicaid Payments per Enrollee, FY2007,* http://www.statehealthfacts.org/comparetable.jsp?cat=4&ind=183. California's payments per enrollee in 2006 were less than 60% of the national average. *Ibid.* There had been no increase in most Medi-Cal payment rates since 2001. 09-958 Pet. App. 114a.

In 2008, the California Legislature enacted Assembly Bill X3 5 (AB 5). AB 5 added Section 14105.19 to the Welfare and Institutions Code, which instructed petitioner Director of the California Department of Health Care Services to cut rates under the Medi-Cal fee-for-service program to physicians, dentists, pharmacies, adult day health care centers, clinics, and other providers by ten percent. 2009-2010 Cal. Stat., 4th Ex. Sess., c. 5, § 36.[2]

Assembly Bill 1183 (AB 1183) superseded those cuts by adding a new Section 14105.191 that required a five-percent cut for certain Medi-Cal fee-for-service payments and benefits, including adult day health care centers and certain hospital services, and a one percent rate reduction for all other fee-for-service benefits (including hospital outpatient services).

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[2] The Director (first Sandra Shewry, then David Maxwell-Jolly, now Toby Douglas) was sued by all respondents in the three certiorari petitions in which the Court granted review. Additional state officials were sued by only one set of plaintiffs in one of the other actions. Yet, for ease of reference, this brief generally refers to petitioners in the plural even when discussing solely the action brought by these respondents.

2008 Cal. Stat. c. 758, §§ 44, 45. Those cuts were repealed for a time in June 2011, but are now back in effect. 2011 Cal. Stat. c. 3, §§ 93.2, 93.5; 2011 Cal. Stat. c. 29, §§ 12, 13.

2. Although the AB 5 cuts were enacted in February 2008, with an effective date of July 1, 2008, California did not submit its proposed state plan amendments to HHS regarding any of the AB 5 cuts or most of the superseding AB 1183 cuts until September 30, 2008. 09-1158 Pet. 9.

On December 24, 2008, HHS requested that California provide additional information within 90 days, stating that the failure to do so could lead to disapproval. 09-1158 *California Pharmacists* Br. in Opp. 1a-20a. California did not respond. *Id.* at 23a. Twenty months after the State's response was due, HHS disapproved the state plan amendments. U.S. Cert. Amicus Br. 1a-4a.

Contrary to petitioners' claim (Pet. Br. 28), HHS did not rely on the existence of the injunctions as a basis for disapproving California's proposed amendments. Instead, HHS explained that it disapproved the proposed plan amendments because the State did not "provide information concerning the impact of the proposed reimbursement reductions on beneficiary access to services," "even though available national data indicate that this may be an issue for California," and did not respond to HHS's request for additional information. U.S. Cert. Amicus Br. 2a-3a.

HHS's additional ground for rejecting the plan amendments was based on the State's long delay in responding to HHS's request, not the existence of the injunctions. Petitioners' proposed amendments requested that the cuts, if approved, be effective retroactive to July 1, 2008. 09-958 Pet. App. 195a, 201a-202a. HHS explained that California's failure to respond raised concerns that "the cumulative effect of a retroactively effective approval of these reimbursement reductions would only serve to exacerbate access concerns." U.S. Cert. Amicus Br. 3a.

California has now sought reconsideration of that disapproval, U.S. Cert. Amicus Br. 5a-7a, which remains pending. Under 42 U.S.C. § 1316(c), HHS's decision to disapprove the proposed plan amendments are "not stayed pending reconsideration." Yet during this entire period—from the effective date of July 1, 2008, through the disapproval by HHS, and continuing to the present—petitioners have implemented the cuts, except when enjoined by federal courts.

C. Proceedings Below

1. No. 09-958

a. The original plaintiffs in the first action (the so-called *ILC* respondents) were Medi-Cal beneficiaries, associations composed of Medi-Cal beneficiaries, and pharmacies who served them. Additional plaintiffs (the intervenor respondents filing this brief) were permitted to intervene during the pendency of the case. Those intervenors are a physician, a dentist, a

medical clinic, and an adult day health care center also participating in the Medi-Cal program.[3]

The original plaintiffs sued petitioners in state court to prevent the implementation of AB 5. Petitioners removed the action from state to federal court. The district court denied the plaintiffs' motion for injunctive relief because Section 30(A) did not create any judicially enforceable "rights." The court of appeals reversed the district court and remanded for consideration of the merits of their motion for preliminary injunction. 09-958 Pet. App. 58a-93a. This Court denied petitioners' certiorari petition. *See* 129 S. Ct. 2828 (No. 08-1223).

b. On remand, the district court issued a preliminary injunction enjoining petitioners from implementing the AB 5 cuts with respect to doctors, dentists, prescription drugs, adult day health care centers, and clinics. 09-958 Pet. App. 94a-124a.

The district court found that respondents demonstrated a likelihood of success. 09-958 Pet. App. 100a-108a. The court found that the cuts would cause "pharmacies to cease selling [generic prescription] drugs to Medi-Cal patients and depriv[e] 'thousands, if not millions' of Medi-Cal beneficiaries of much-needed pharmaceuticals." *Id.* at 110a. It also found that pharmacies would "limit the scope of the

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[3] Adult day health care centers provide an alternative to institutional care. Cal. Health & Safety Code § 1570.2.

services they provide to Medi-Cal beneficiaries, by, *inter alia*, discontinuing the provision of at least some prescription drugs * * *, turning away new Medi-Cal patients, or by laying-off pharmacy employees, and/or reducing pharmacy hours." *Id.* at 111a.

In addition, the court found that the rate reduction would cause doctors and other service providers (who had not received a rate increase since 2001) to "turn away" new Medi-Cal patients and either "stop treating [current] Medi-Cal patients, or, at a minimum, * * * reduce the services" provided to them. 09-958 Pet. App. 116a-117a. This reduction in services "increased the burden on emergency rooms and community health clinics" and forced some adult day health care centers to close. *Id.* at 117a-118a.

Weighing the balance of the hardships and the public interest, the district court concluded that the "significant threat to the health of Medi-Cal recipients" that "reducing payments to health-care service providers will likely cause" outweighed any expected fiscal savings. The district court noted such savings were unlikely to materialize because "many Medi-Cal beneficiaries will turn to more costly forms of medical care, such as emergency room care." 09-958 Pet. App. 121a-122a & n.14.

The district court issued a similar preliminary injunction for providers of non-emergency medical transportation services and providers of home health services in the Medi-Cal fee-for-service program. 09-958 Pet. App. 133a-153a. The district court found

that the cuts have "forced or will force [non-emergency medical transportation services] and home health services providers to reduce the geographic area they are able to serve, to decline to take new Medi-Cal patients, and, in some cases, to cease furnishing services to existing Medi-Cal patients" and to "close their business" altogether. *Id.* at 148a-149a. This curtailment of services had "already prevented altogether some Medi-Cal beneficiaries from obtaining needed [medical] services" and forced others to enter nursing homes. *Id.* at 150a-151a.

c. The court of appeals affirmed in part, reversed in part, and remanded. 09-958 Pet. App. 1a-38a, 54a-57a.

The court affirmed the district court's determination that respondents had established a likelihood of success on the merits on three independent grounds. 09-958 Pet. App. 10a-29a. First, "quite apart from any procedural requirements * * *, the State's decision to reduce Medi-Cal reimbursement rates based solely on state budgetary concerns violated federal law." *Id.* at 20a. Second, the court of appeals held that the rate cut was not the result of a "reasonable and sound" decision-making process and thus failed the interpretation of Section 30(A) urged by petitioners in that appeal. *Id.* at 22a n.12. Third, the court held that petitioners had not complied with the requirements of Section 30(A) as previously interpreted. *Id.* at 10a-12a (citing *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491 (9th Cir. 1997), cert. denied, 522 U.S. 1044 (1998)).

The court of appeals noted that "the cuts have apparently forced at least some providers to stop treating Medi-Cal beneficiaries." 09-958 Pet. App. 23a. In a separate unpublished opinion, the court of appeals also held that there was no clear error in the district court's conclusion "that the rate reductions would force—or, in some cases, were already forcing—[non-emergency medical transportation] and home health-care agencies to reduce the geographic area served, decline to take new Medi-Cal patients, or stop treating Medi-Cal patients altogether." *Id.* at 56a.

On respondents' cross-appeal, the court of appeals found that petitioners had waived their Eleventh Amendment immunity by removing the case from state to federal court. 09-958 Pet. App. 33a-37a. The court observed that California law creates a cause of action for mandamus which permits "monetary awards against a state agency or official resulting from unlawfully withheld health and welfare payments." *Id.* at 34a-35a (citing California cases). The court of appeals thus remanded with instructions that "the district court's injunction should extend to all services covered by that injunction and provided on or after" the cuts went into effect. *Id.* at 37a.

d. A month after the denial of petitioners' petition for rehearing en banc, petitioners asked the court to vacate its opinion and dismiss the appeals as moot because the challenged cuts of AB 5 were no longer in effect. The court of appeals rejected petitioners' motion. 09-958 Pet. App. 41a-51a. Petitioners have made all the required payments to respondents.

2. No. 09-1158

Meanwhile, the *California Pharmacists* respondents (including hospitals and adult day health care centers, associations representing those providers, and two individuals who receive Medi-Cal services) sued petitioners to prevent the implementation of AB 1183's five-percent/one-percent cuts.

a. The district court granted respondents' motion for a preliminary injunction as applied to adult day health care centers but not as to hospitals. 09-1158 Pet. App. 84a-105a. The district court found respondents had established irreparable injury to Medi-Cal beneficiaries due to the proposed cuts because they would be "at risk of losing access" to adult day health care services. *Id.* at 102a. That, in turn, created a "significant threat to the health of Medi-Cal recipients." *Id.* at 103a. The balance of hardships and public interest also weighed in favor of a preliminary injunction as to adult day health care centers, the district court found, because the proposed cuts might not save the State any money because "many Medi-Cal beneficiaries may turn to more costly forms of medical care, such as emergency room care." *Id.* at 103a n.7. The district court denied respondents' motion as applied to hospitals, however, on the ground that respondents had not established irreparable injury. *Id.* at 106a-127a.

b. The court of appeals affirmed the district court's entry of a preliminary injunction regarding the rate cut as applied to adult day health care

centers. 09-1158 Pet. App. 1a-36a. The court of appeals held that the district court did not commit clear error in finding that the legislature was concerned "solely with budgetary matters." *Id.* at 20a. Further, the court of appeals noted that petitioners "concede[ ] that here, the evidence indicates that at least some [providers] would stop treating beneficiaries due to AB 1183." *Id.* at 33a. The court of appeals reversed the district court's denial of a preliminary injunction regarding the cuts as applied to hospitals because the district court had abused its discretion in finding a lack of irreparable injury. *Id.* at 37a-41a.[4]

SUMMARY OF ARGUMENT

I.

A. Petitioners and their amici acknowledge that there is a federal equitable cause of action to enjoin state laws preempted under the Supremacy Clause. In this they are certainly correct. This Court has adjudicated on the merits dozens, and perhaps hundreds, of cases seeking injunctive relief against state officials based on the preemption of state laws by federal statutes.

To exclude the preemption suits here, petitioners improperly attempt to limit the scope of that equitable cause of action to suits brought in anticipation of

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[4] The lower courts did not reach respondents' alternative argument that the rate cuts were prohibited because they were implemented without approval from HHS. *See* 09-1158 Pet. App. 120a n.9; 09-55365 Resp. C.A. Br. 39.

some coercive suit by the State. But this Court's past private suits seeking injunctions based on preemption of state laws have encompassed situations in which there was no potential state court litigation. And no sound reason justifies limiting the federal cause of action solely to anticipatory actions.

Petitioners' rigid rule would create a system where federal courts would be open only when state courts also would be available to resolve the federal question as a defense. Under their view, federal courts would not be open when there is no state court available to address the federal question. But when a state court is not available, the need for a federal judicial forum is even more critical. Petitioners would leave the federal judiciary, including this Court, completely unavailable to protect the federal-state balance.

B. Congress ratified this equitable cause of action by enacting the Three-Judge Court Act, the Johnson Act, and the Tax Injunction Act. These laws reflect Congress's general acceptance of a federal cause of action to enjoin state officials from implementing preempted state laws, save with regard to specific substantive areas.

C. Section 1983 does not preclude these suits. That statute was enacted in 1871 to expand access to federal courts, not to displace existing causes of actions. Section 1983 is broader in its remedies than the equitable cause of action, and this Court has interpreted the word "rights" in Section 1983 as a

limitation. But nothing suggests that Congress intended to limit a federal court's authority to stop state officials from implementing preempted state laws. An "injured party does not need § 1983 to vest in him a right to assert that an attempted exercise of jurisdiction or control violates the proper distribution of powers within the federal system." *Golden State Transit Corp. v. City of Los Angeles*, 493 U.S. 103, 114 (1989) (Kennedy, J., dissenting).

D. Nor is the term "right" some talismanic, trans-substantive requirement that always must be satisfied to obtain relief in federal court. The statutory bases for the power of federal courts to enjoin state officials from implementing preempted state laws—the jurisdictional statutes and the authority to grant injunctions and writs—simply do not limit jurisdiction to those who can show the deprivation of a "right."

The implied cause of action cases, such as *Cort v. Ash*, 422 U.S. 66 (1975), usually involve a damages claim under a particular federal statute against *private* parties. Those cases do not implicate the federal-state balance and are not apposite because the Supremacy Clause governs directly only parties acting under color of law in their official capacities. Thus, a federal suit to enjoin implementation of preempted state laws runs only against parties like petitioners here.

II.

A. Medicaid, like other federal statutes enacted pursuant to the Spending Clause, preempts conflicting state laws. That such statutes ultimately involve a State's "voluntary agreement" to participate in the federal program does not alter their preemptive effect, just as it does not alter the status of similar Commerce Clause statutes. Indeed, federal laws would be continually frustrated if public entities that accepted federal money (or federal regulatory authority) could rely on state law as an excuse for not complying with federal law.

B. This Court has thrice rejected the argument that the structure of Medicaid (or similar Spending Clause statutes) reflects any congressional intent to preclude federal courts' authority to enjoin implementation of preempted state laws. Most importantly, nothing in the statute or regulations permits private parties to trigger an administrative review to ensure that a recipient complies with federal law. Thus, this case has none of the statutory protections for individuals that this Court found material in *Astra USA, Inc. v. Santa Clara County*, 131 S. Ct. 1342 (2011).

Furthermore, the federal Department of Health and Human Services lacks effective tools to timely address rate cuts or other reductions in services. All HHS can do is threaten to withhold all federal funding from the Medi-Cal program. But even if it ultimately were to do so (perhaps many years after cuts were implemented), that would injure the very

beneficiaries the Medicaid program is designed to assist and protect. These cases are perfect examples of HHS's impotence. Petitioners implemented the proposed rate cuts months before they even submitted them to HHS for approval. And despite HHS's ultimate disapproval of the cuts (almost three years after they were enacted and more than two years after they were submitted for review), petitioners nevertheless continue to pay the unapproved lower rates to providers, except where federal courts have enjoined them from doing so.

C. Likewise, Congress did not preclude private enforcement of Section 30(A)'s preemptive effect. Section 30(A) has substantive content that is well within the judicial ken, and Congress expected private litigation over compliance with Section 30(A). Petitioners point to the repeal of the Boren Amendment. But when Congress repealed that provision, it refused to repeal Section 30(A) or to limit private enforcement of Medicaid.

III.

Petitioners concede that they waived any argument that respondent beneficiaries lack prudential standing. But they also waived the argument they belatedly press here as to respondent providers, as they did not press it in either the court of appeals or in their certiorari petitions.

In any event, respondents possess prudential standing. Just as a person has prudential standing to argue that "[t]he public policy of [a State], enacted in

its capacity as sovereign, has been displaced by that of the National Government," *Bond v. United States*, 131 S. Ct. 2355, 2366 (2011), a person has prudential standing to argue that a law enacted by a State has been displaced by the National Government.

Further, to the extent relevant, Section 30(A) itself was enacted to ensure that beneficiaries received medical services by creating sufficient incentives for doctors and other providers to offer services to Medicaid patients. As beneficiaries of medical services and the providers of those services, respondents have interests in the amount providers are paid that are, at the very least, arguably protected by the statute. Indeed, the facts of these cases show that the rate cuts would have a significant and immediate detrimental impact on both beneficiaries and providers.

ARGUMENT

The federal courts long have granted private persons injunctions and writs when government officials at the state and federal levels act outside the scope of their legitimate authority. The authority of such officials is limited not just by the prohibitions of the Constitution itself, but by all valid federal laws, which the Constitution provides "shall be the Supreme Law of the Land." U.S. Const. Art. VI, cl. 2. A state official who acts in violation of a federal statute is in the same position as a state official who acts in violation of the Constitution. Both have upset the "constitutional balance between the National Government and the States" established by the Supremacy

Clause. *Bond v. United States*, 131 S. Ct. 2355, 2364 (2011).

In both cases, the officials have exceeded their state authority and are stripped of any immunities. And in both cases, federal courts must be available to grant injunctions and writs to prevent irreparable injury to persons concretely injured by those violations. Such a cause of action exists apart from 42 U.S.C. § 1983 or any express or implied cause of action under a particular federal statute.

I. THE ACKNOWLEDGED AND LONGSTANDING EQUITABLE CAUSE OF ACTION TO KEEP GOVERNMENT OFFICIALS WITHIN THE SCOPE OF THEIR AUTHORITY INCLUDES SUITS BY INJURED INDIVIDUALS TO ENJOIN IMPLEMENTATION OF STATE LAWS THAT CONFLICT WITH FEDERAL LAW

Petitioners and their amici rightly acknowledge that there is a federal equitable cause of action to enjoin state laws preempted under the Supremacy Clause. Petitioners acknowledge that, even absent any express cause of action a person may be "a plaintiff in a lawsuit filed to forestall future state (or local) enforcement of state (or local) regulation of the party's conduct." Pet. Br. 43.

The United States as amicus likewise agrees that there is a "nonstatutory cause of action to enjoin enforcement of state action that is inconsistent with federal law." U.S. Br. 20. It describes this cause of

action as "well established," having "considerable historical grounding" and observes that it "serves an important purpose in vindicating the supremacy of federal law." U.S. Br. 21 & n.7.

The National Governors Association also agrees that it is "now largely uncontroversial" that persons may "obtain relief in form of a writ of injunction or prohibition" from a federal court "against the enforcement of a pre-empted State law." NGA Br. 23-24.

They are all correct to acknowledge that this federal equitable cause of action exists, and yet they improperly attempt to limit its scope. To do so, they borrow from inapposite case law that is tied to particular statutory text and motivated primarily by concerns regarding damages relief that are inapplicable to this cause of action.

A. A Cause Of Action To Enjoin State Officials From Implementing Preempted State Laws Has Been Recognized By This Court For Almost Two Centuries

1. Individuals harmed by state officials' implementation of preempted state laws have a federal cause of action to enjoin such conduct

a. From its earliest era, this Court has held that a federal court that has subject-matter jurisdiction may grant an injunction or writ at the behest of an individual who has standing to bring a government official into compliance with federal law. *See Osborn v. Bank of the United States*, 22 U.S. 738

(1824). "The federal courts of the early nineteenth century had occasionally issued injunctions at the behest of private litigants against state officials to prevent the enforcement of state statutes * * * " *Swift & Co. v. Wickham*, 382 U.S. 111, 117 (1965). That practice increased after Congress gave federal courts arising-under-federal-law subject-matter jurisdiction in 1875. *See ibid.*

Ex parte Young, 209 U.S. 123 (1908), is a significant example of this cause of action. Contrary to petitioners' claim (Pet. Br. 41), that decision was not limited "only" to the question whether the Eleventh Amendment barred the grant of an injunction. In that case, complete diversity between the parties was lacking, *id.* at 143, and the Court thus also held that the federal courts had subject-matter jurisdiction to hear the claim under its federal-question jurisdiction. *Id.* at 145 ("We conclude that the circuit court had jurisdiction in the case before it, because it involved the decision of Federal questions arising under the Constitution of the United States.").

Given the well-pleaded complaint rule and general rule that a "suit arises under the law that creates the cause of action," *American Well Works Co. v. Layne & Bowler Co.*, 241 U.S. 257, 260 (1916), this holding has been understood by leading judges and commentators alike as recognizing a federal cause of action to enjoin state officials who come into conflict with the Constitution or federal laws. *See, e.g.*, *Planned Parenthood of Houston & Se. Tex. v. Sanchez*, 403 F.3d 324, 332-334 (5th Cir. 2005) (Higginbotham,

J.); *Crawford-El v. Britton*, 93 F.3d 813, 831-832 (D.C. Cir. 1996) (en banc) (Silberman, J., concurring), rev'd on other grounds, 523 U.S. 574 (1998); Richard H. Fallon, Jr., Daniel J. Meltzer & David L. Shapiro, *Hart and Wechsler's The Federal Courts and The Federal System* 903 (5th ed. 2003); 13D Charles A. Wright, Arthur R. Miller & Edward H. Cooper, *Federal Practice and Procedure* § 3566 (3d ed. 2008).

Indeed, this Court recently relied on *Ex parte Young* to rebut the United States's view that no cause of action existed to challenge federal legislation as unconstitutional under separation-of-powers principles. The Court held that equitable relief against both state *and* federal officials "has long been recognized as the proper means for preventing entities from acting unconstitutionally." *Free Enterprise Fund v. Public Co. Accounting Oversight Bd.*, 130 S. Ct. 3138, 3151 n.2 (2010) (quoting *Correctional Servs. Corp. v. Malesko*, 534 U.S. 61, 74 (2001)); *see also Mitchum v. Hurt*, 73 F.3d 30 (3d Cir. 1995) (Alito, J.).

b. This cause of action against state officials includes enforcement of the Supremacy Clause's preemptive effect on state laws that conflict with federal laws. That is because, first, preemption claims are constitutional claims. *See Brown v. Hotel & Rest. Emps. Int'l Union Local 54*, 468 U.S. 491, 501 (1984) (preemption occurs "by direct operation of the Supremacy Clause"); *Douglas v. Seacoast Prods., Inc.*, 431 U.S. 265, 271-272 (1977) (noting that preemption is "basically constitutional in nature, deriving its force from the operation of the Supremacy Clause");

City of Phila. v. New Jersey, 430 U.S. 141, 142 (1977) ("federal pre-emption of state statutes is, of course, ultimately a question under the Supremacy Clause"); *Hagans v. Lavine*, 415 U.S. 528, 533 n.5 (1974) ("a suit to have a state statute declared void and to secure the benefits of the federal statute with which the state law is allegedly in conflict cannot succeed without ultimate resort to the Federal Constitution").

There is no basis why this constitutional claim "should be treated differently than every other constitutional claim" in terms of private enforcement. *Free Enterprise Fund*, 130 S. Ct. at 3151 n.2 (rejecting that argument as to separation-of-powers claim). To the contrary, the Supremacy Clause vindicates individual liberty through the so-called "vertical" separation of powers by limiting encroachment by the States on the national power and vice-versa. *See Bond*, 131 S. Ct. at 2364 (analogizing separation-of-powers and federalism principles). This Court thus recently confirmed that "[a]n individual has a direct interest in objecting to laws that upset the constitutional balance between the National Government and the States when the enforcement of those laws causes injury that is concrete, particular, and redressable." *Ibid.*

In addition, this Court already has permitted federal courts to exercise the same authority respondents invoke here to bring *federal* executive officials into compliance with federal law. Under the doctrine of "non-statutory review," this Court has recognized a federal equitable cause of action based on federal-question jurisdiction and the federal

courts' equity and writ authority. *See* Antonin Scalia, *Sovereign Immunity and Nonstatutory Review of Federal Administrative Action: Some Conclusions from the Public-Lands Cases*, 68 Mich. L. Rev. 867, 870 n.12 (1969-1970). Thus, even in the absence of an express cause of action or a statute like the Administrative Procedure Act (APA), if "an official violates the law to the injury of an individual the courts generally have jurisdiction to grant relief." *American School of Magnetic Healing v. McAnnulty*, 187 U.S. 94, 108 (1902); *see also Dalton v. Specter*, 511 U.S. 462, 474 (1994) ("some claims that the President has violated a statutory mandate are judicially reviewable outside the framework of the APA"); *Harmon v. Brucker*, 355 U.S. 579, 581-582 (1958) ("[g]enerally, judicial review is available to one who has been injured by an act of a government official which is in excess of his express or implied powers"); *Abbott Labs. v. Gardner*, 387 U.S. 136, 142-143 (1967) (describing understanding of Congress in the 1930's regarding existence of "traditional channels of review" of federal executive action); Scalia, *supra*, at 913-916 (collecting cases in postal, public lands, and taxing areas).

For example, in *Chamber of Commerce v. Reich*, 74 F.3d 1322 (D.C. Cir. 1996), the court of appeals examined the lawfulness of a federal Executive Order providing that federal contractors would be debarred from bidding on future government contracts if they permanently replaced striking workers. The plaintiffs claimed the Order was contrary to federal statutes. The court, through Judge Silberman, concluded

that the APA's statutory cause of action did not apply. It nonetheless held that as long as the federal court has subject-matter jurisdiction, "we have never held that a lack of a statutory cause of action is per se a bar to judicial review." *Id.* at 1328. *Accord Trudeau v. FTC*, 456 F.3d 178, 189-190 (D.C. Cir. 2006) (Garland, J.) ("'judicial review is available when an agency acts ultra vires,' even if a statutory cause of action is lacking").

Non-statutory review, like the equitable cause of action at issue in this case, reflects the undisputed role that federal courts have played, apart from any express cause of action, in ensuring that executive officials do not exceed the bounds of federal law.

c. Consonant with *Osborn*, *Ex parte Young*, and the non-statutory review cases, this Court has adjudicated on the merits dozens, and perhaps hundreds, of cases seeking injunctive relief against state officials based on the preemption of state laws by federal statutes. *See* Br. of *Dominguez* Resp. Appendix (listing such cases). To be sure, the Court's decisions generally were silent as to the cause of action. Even so, those decisions "have much weight, as they show that this point neither occurred to the bar or the bench." *Bank of the United States v. Deveaux*, 9 U.S. (5 Cranch) 61, 88 (1809) (Marshall, C.J.). And at least some members of this Court have opined that plaintiffs may "vindicate" some types of "preemption claims by seeking declaratory and equitable relief in the federal district courts through their powers under federal jurisdictional statutes." *Golden State Transit*

Corp. v. City of Los Angeles, 493 U.S. 103, 119 (1989) (Kennedy, J., dissenting).

d. Moreover, this Court repeatedly has held that there is federal-question jurisdiction over suits brought against state officials seeking such injunctive relief. For example, in *Verizon Maryland Inc. v. Public Service Commission*, 535 U.S. 635 (2002), Verizon sought "relief from the [state] Commission's order 'on the ground that such regulation is preempted by a federal statute which, by virtue of the Supremacy Clause of the Constitution, must prevail.'" *Id.* at 642 (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96 n.14 (1983)). This Court held that Verizon's claim "'thus presents a federal question which the federal courts have jurisdiction under 28 U.S.C. § 1331 to resolve.'" *Ibid.*

Although federal court jurisdiction can be established with only a colorable (as opposed to actual) federal cause of action, *see ibid.*, it would be quite surprising more than a century after *Ex parte Young* to discover that in fact there is no cause of action to adjudicate such preemption suits. That is why the United States in *Verizon* relied on *Shaw* to expressly urge that Verizon had "a claim for equitable relief under the Supremacy Clause and the federal jurisdictional statutes on the ground that an Act of Congress preempts a state regulatory action." U.S. Reply Br., *Verizon Md. Inc. v. Public Serv. Comm'n*, Nos. 00-1531, 00-1711, at 8 (Nov. 2001).

2. *The scope of the equitable cause of action includes all persons injured by preempted state laws, and is not limited to claims that merely raise defenses anticipatorily*

This federal equitable cause of action allows anyone harmed by implementation of a preempted state law to obtain injunctive relief. Petitioners thus are wrong to assert (Pet. Br. 43-44) that the federal equitable cause of action, which they ultimately acknowledge exists, is limited to suits brought in anticipation of some coercive suit by the State. But even if it were, this suit fits squarely in that model. California provides that those who participate in Medi-Cal will be penalized monetarily if they charge a patient any money other than the rate set by petitioners. *See* Cal. Welf. & Inst. Code § 14019.4(a) & (c); *see also id.* § 14123(a) (provider also may be suspended from Medi-Cal for violating any statutory provision). The validity of the rate set by petitioners (and whether that rate is preempted) thus could be addressed as part of an action the State could bring against the provider respondents.

In any event, the equitable cause of action is not so limited. One of petitioners' amicus asserts that "every case in which this Court has upheld relief based on federal supremacy" has met that requirement. NGA Br. 25. But as the United States noted at the certiorari stage, "not all of this Court's cases necessarily fit that description." U.S. Cert. Amicus Br. 18. To the contrary, this Court's cases also have

encompassed situations in which the State does not seek to regulate a party directly, but still acts with respect to that party in a way preempted by federal law.

Crosby v. National Foreign Trade Council, 530 U.S. 363 (2000), is one of those situations. In that case, the State maintained a list of companies with which it would not do business, including companies that did business with Burma. There was no formal process before a company was placed on the State's list; the only available challenge by a company to inclusion on the list was submission of an affidavit stating that it did no business in Burma. *Id.* at 368 n.2. There was no judicial or administrative action that the State could, or needed to, bring against the listed companies. This Court nonetheless permitted companies to bring a successful suit for injunctive relief claiming preemption of that state law.

Indeed, the United States pointed to *Crosby* in its certiorari-stage brief as evidence that the cause of action extended beyond anticipation of a coercive suit by the State. U.S. Cert. Amicus Br. 18. Now, however, it contends that the law in *Crosby* was an "exercise of the State's authority to impose and enforce what were essentially state regulatory standards." U.S. Br. 23 n.8. But the state law was only "regulatory" in the sense that it used the State's spending power, instead of its police power, to achieve its goals. The same is true here. California wants medical providers to provide services to people at a fixed price, so it allows participation in its Medi-Cal program only

to those who will accept the rates it pays and will not charge the patient any additional money.

Moreover, *Crosby* is hardly an outlier. This Court has addressed other preemption claims where the state law could not result in any form of judicial proceedings in which the plaintiff could raise preemption as a defense. *See Pharmaceutical Research & Mfrs. of Am. v. Walsh*, 538 U.S. 644 (2003) (State refused to buy drugs from a company under Medicaid unless the company gave the State a rebate); *Dalton v. Little Rock Family Planning Servs.*, 516 U.S. 474 (1996) (State refused to pay for certain medical services required by Medicaid); *Perez v. Campbell*, 402 U.S. 637 (1971) (State automatically suspended driver's license of a person who failed to pay a judgment discharged under Bankruptcy Act); *see also Engine Mfrs. Ass'n v. South Coast Air Quality Mgmt. Dist.*, 541 U.S. 246 (2004) (finding state regulation governing private parties' purchasing decisions preempted; leaving for remand the question whether state regulation governing its own purchase decisions also was preempted); *California Div. of Labor Standards Enforcement v. Dillingham Constr., N. Am., Inc.*, 519 U.S. 316 (1997) (after state agency ordered contractor to withhold certain payments from subcontractor, subcontractor sued state agency arguing that state agency's order to contractor was preempted by ERISA).

While these repeated decisions do not squarely hold that the federal equitable cause of action extends to these preemption suits, preemption suits of this

type are a consistent portion of the federal courts' docket. And this Court regularly reviews them without question. It would be surprising to learn that none of these cases should have been heard in federal court.

Petitioners' amici, who like petitioners admit such a federal cause of action exists, assert that the history of equity limits such actions to "negative injunctive relief" for those who have "a legal defense (such as pre-emption) to an impending legal action." NGA Br. 25-26. But the injunctions in these cases are negative injunctions—they simply prohibit the state officials from implementing a cut in existing rates. Further, equity causes of action were not limited solely to anticipatory legal defenses. *See* Br. of *Dominguez* Resp. 12-13, 40-42. And even if they had been, the "'flexibility' inherent in 'equitable procedure' enables courts 'to meet new situations [that] demand equitable intervention, and to accord all the relief necessary to correct . . . particular injustices.'" *Holland v. Florida*, 130 S. Ct. 2549, 2563 (2010). There is no sound reason today to limit the federal cause of action solely to anticipatory actions. *Cf. Jackson v. Birmingham Bd. of Educ.*, 544 U.S. 167 (2005) (determining whether an existing cause of action extends to certain conduct does not require the same inquiry as whether cause of action exists in first instance).

The rigid rule proposed by petitioners and their amici for cabining the existing cause of action is particularly unwarranted. They ask this Court to

create a system where federal courts would be open only when state courts would also be available to resolve the federal question as a defense. Under their view, however, federal courts would not be open when there is no state court available to address the federal question. But when a state court is not available, the need for a federal judicial forum is even more critical. Petitioners would leave the federal judiciary, including this Court, completely unavailable to protect the federal-state balance.

B. Congress Has Ratified The Existing Equitable Cause Of Action To Enjoin Conduct Implementing Preempted State Laws By Enacting Specific Federal Laws That Address It, Rather Than Abolish It

In light of a growing number of federal court challenges to state legislation, Congress considered at the beginning of the Twentieth Century a variety of responses to the authority of federal courts to enjoin state officials. Congress ultimately adopted two narrow approaches that signaled its general acceptance of the federal cause of action to enjoin state officials who were implementing state laws contrary to the Constitution and laws of the United States.

1. Shortly after this Court's decision in *Ex parte Young*, the House of Representatives passed a bill that would have amended what is now Section 1331 to deprive district courts of jurisdiction over actions "to suspend, enjoin, or restrain the action of any officer of a State in the enforcement, operation, or

execution of a statute of such State, upon the ground of the unconstitutionality of such statute." 46 Cong. Rec. 3998, 4001 (1911) (reprinting conference report).

The Conference Committee struck that provision, however, and substituted a provision requiring a three-judge court to convene to enter such an injunction and for an appeal to be available directly to this Court. *Id.* at 4001-4002. Congress enacted that substitute. *See* Judicial Code of 1911, ch. 231, § 266, 36 Stat. 1087, 1162 (codified as amended at 28 U.S.C. § 2281 before its repeal by Pub. L. No. 94-381, § 1, 90 Stat. 1119, 1119 (1976)). That statute reflected Congress's judgment that although federal courts should have the power to enjoin state officials from implementing state statutes, the decision should not rest in the hand of a single district court judge. *See Florida Lime & Avocado Growers, Inc. v. Jacobsen*, 362 U.S. 73, 77 (1960) (describing three-judge court provision as "cushioning the impact of the *Young* case").

For the first 15 years after its enactment, in about 10% of the cases heard by this Court under this provision, the "state regulation was alleged to be precluded by or to conflict with some existing and controlling federal law." Welch Pogue, *State Determination of State Law and the Judicial Code*, 41 Harv. L. Rev. 623, 632 & n.41 (1927-1928); *see also Michigan Cent. R.R. v. Michigan Pub. Util. Comm'n*, 271 F. 319 (E.D. Mich. 1921) (three-judge court) (holding Supremacy Clause claim triggered requirement for three-judge court). Justice Frankfurter, writing for the Court, held that "[n]either the language of

§ 2281 nor the purpose which gave rise to it affords the remotest reason for carving out an unfrivolous claim of unconstitutionality because of the Supremacy Clause from the comprehensive language of § 2281." *Kesler v. Department of Pub. Safety*, 369 U.S. 153, 156 (1962).

Although this Court in 1965 ultimately reversed course and held that the three-judge court provisions did not apply to Supremacy Clause challenges, *see Swift & Co. v. Wickham*, 382 U.S. 111 (1965), it did so with heavy reliance on judicial administration (i.e., concern regarding numerous three-judge court actions with mandatory appeal to this Court). *Id.* at 128-129. No suggestion was made that Congress was not aware of preemption challenges when it enacted the three-judge court provisions or that it disapproved of them in any way. Instead, this Court concluded that actions claiming preemption would not have been as troubling to Congress as substantive due process cases. That was so, the Court reasoned, because "single-judge decisions in conflict and preemption cases were always subject to the corrective power of Congress." *Id.* at 127.

2. After several years of experience with the three-judge court provision, some members of Congress renewed efforts to establish broad limits on federal court jurisdiction over injunctive suits against state officials. *See* Note, *Limitation of the Jurisdiction of the Federal District Courts in Public Utility Rate Litigation*, 20 Iowa L. Rev. 128, 133 (1934-1935) (collecting proposed bills). Instead of removing such

jurisdiction generally, however, Congress channeled the power of the federal courts to enjoin state officials with regard to certain substantive areas. In doing so, it reaffirmed the availability of the equitable cause of action in all other areas.

The Johnson Act of 1934, ch. 283, § 1, 48 Stat. 775 (codified at 28 U.S.C. § 1342), for example, expressly carved out actions claiming preemption from its exclusion of federal court jurisdiction. That statute provides that a district court "shall not enjoin, suspend or restrain the operation of, or compliance with, any order affecting rates chargeable by a public utility and made by a State administrative agency" so long as a "plain, speedy and efficient remedy may be had in the court of such State." Additional language in the Johnson Act excludes preemption claims from its scope, however, by exempting orders that "interfere with interstate commerce." *See Public Utils. Comm'n v. United Fuel Gas Co.*, 317 U.S. 456, 469-470 (1943) (holding that the Johnson Act did not bar federal injunction against preempted state order). Thus, the Johnson Act continues to permit preemption claims to be brought in federal court even though other federal constitutional claims are channeled to state court. *See Freehold Cogeneration Assocs., L.P. v. Board of Regulatory Comm'rs*, 44 F.3d 1178, 1186 (3d Cir.) (collecting modern cases), cert. denied, 516 U.S. 815 (1996).

The fine-tuned language in the Johnson Act contrasts with the Tax Injunction Act (TIA), enacted three years later. *See* Act of Aug. 21, 1937, ch. 726,

§ 1, 50 Stat. 738 (codified at 28 U.S.C. § 1341). "The language of the TIA differs significantly from that of the Johnson Act." *Hibbs v. Winn*, 542 U.S. 88, 105 n.7 (2004). Unlike the Johnson Act, Congress provided no exceptions in the TIA to a broad divestiture of district court jurisdiction regarding tax collection in deference to state courts. This broader language made clear that Congress did not intend to permit federal courts to entertain preemption claims regarding state taxes so long as there was "a plain, speedy and efficient remedy" in state courts. *See Ashton v. Cory*, 780 F.2d 816, 821-824 (9th Cir. 1986) (Kennedy, J.).

Thus, although Congress's approach to federal jurisdiction varied on certain occasions for certain types of claims, the various statutes together reflect Congress's general acceptance of a cause of action to enjoin state officials from implementing preempted state laws in those circumstances where it did not expressly remove federal court jurisdiction.

C. Section 1983 Was Not Intended To Limit This Distinct Cause Of Action

Petitioners rely heavily on the case law developed by this Court under 42 U.S.C. § 1983, and argue that the rules adopted by this Court to determine whether a statute secures "rights" should dictate the limits of a federal court's authority to stop state officials from implementing preempted state laws. Pet. Br. 21-23. But nothing suggests that Congress intended those limits to be imported into this distinct cause of action. "Despite what one might think from

the increase of litigation under the statute in recent years, § 1983 does not provide the exclusive relief that the federal courts have to offer." *Golden State*, 493 U.S. at 119 (Kennedy, J., dissenting).

a. In the last quarter of the Nineteenth Century, this Court recognized that the two causes of action were distinct and that just because an action could not be brought under Section 1983 did not exclude all federal relief. Thus, even though the Court held in *Carter v. Greenhow*, 114 U.S. 317 (1885), that the Contracts Clause did not secure rights enforceable through Section 1983, it noted that Congress "has legislated in aid of the rights secured by that clause of the Constitution * * * by conferring jurisdiction upon the [lower federal] courts * * * of all cases arising under the constitution and laws of the United States, where the sum or value in dispute exceeds $500." *Id.* at 322-323. And on the same day, it expressly permitted a case under the Contracts Clause to proceed under the arising-under-federal-law statute. *See White v. Greenhow*, 114 U.S. 307, 308 (1885).

This Court later explained that even though a suit could not be brought under Section 1983, "[i]f state legislation impairs the obligations of a contract, or deprives of property without due process of law, or denies the equal protection of the laws * * * remedies are found in [the predecessor to Section 1331], giving to the circuit courts jurisdiction of all cases arising under the Constitution and laws of the United States." *Holt v. Indiana Mfg. Co.*, 176 U.S. 68, 72 (1900). Although the statutory provision cited by the

Court was a jurisdictional one, the *Holt* Court understood such a jurisdictional grant to confer the equitable power to enjoin government officials from exceeding their lawful authority. *Holt* was issued at the same time *Ex parte Young* and non-statutory review cases were cementing into the case law that already-longstanding equitable cause of action.

b. These holdings are consistent with the purposes underlying Section 1983. Section 1983 was enacted in 1871 to expand access to federal courts, not to displace existing causes of actions. Indeed, the legislative history reflects that Congress intended Section 1983 to go beyond the cause of action already available under the "power-allocating provisions" of the Constitution. *Dennis v. Higgins*, 498 U.S. 439, 455 (1991) (Kennedy, J., dissenting).

Thus one of the bill's sponsors, Representative Shellabarger, explained that existing, pre-Fourteenth Amendment constitutional "prohibitions upon the [police] powers of the States are all of such nature that they can be, and even have been, when the occasion arose, enforced by the courts of the United States declaring void all State acts of encroachment on Federal powers." *Ibid.* (quoting Cong. Globe, 42d Cong., 1st Sess., App. 69-70 (1871)). Similarly, Senator Thurman, an opponent of the bill, explained that "in respect to this class of provisions, which are limitations upon the powers of the States," they already were "protected through the Federal judiciary." Cong. Globe, 42d Cong., 1st Sess., App. 221 (1871).

c. Section 1983's remedies are much broader than those available under this federal equitable cause of action. Section 1983 authorizes damages (including punitive damages) against officials in their individual capacities. *See Smith v. Wade*, 461 U.S. 30 (1983). In addition, federal courts have broader injunctive authority under Section 1983 than under other causes of action because Section 1983 is an express exception to the Anti-Injunction Act's prohibition against enjoining state court proceedings. *See Mitchum v. Foster*, 407 U.S. 225 (1972). And (since 1976), prevailing plaintiffs can recover attorneys' fees against officials in both their individual and official capacities. 42 U.S.C. § 1988(b); *Hutto v. Finney*, 437 U.S. 678 (1978).

Section 1983 also, for a substantial period of time, provided for broader jurisdiction for federal courts than was otherwise generally available to seek injunctive relief against state officials. Congress granted federal courts jurisdiction over Section 1983 actions without regard to the amount in controversy. *See Chapman v. Houston Welfare Rights Org.*, 441 U.S. 600, 608 (1979). At the time of Section 1983's enactment, federal courts did not possess general arising-under-federal-law jurisdiction. Even when Section 1331's predecessor authorized general federal question jurisdiction, it contained an amount-in-controversy requirement (equal to that of diversity) until 1980. *See Hart and Wechsler's*, *supra*, 1473. That amount was "impossible to meet" for many beneficiaries challenging state welfare laws as preempted.

Hagans, 415 U.S. at 552-553 (Rehnquist, J., dissenting). That jurisdictional barrier was one of several reasons litigants sought to have their claims fit within the scope of Section 1983, rather than simply press them under the equitable cause of action.

Thus, given their distinct histories and distinct remedies, there is no reason to think that Congress intended Section 1983 to limit the equitable cause of action invoked by respondents here. Instead, this cause of action is a longstanding, albeit bare bones, action needed to ensure that persons can seek injunctive relief in federal court to prohibit injuries caused by state efforts to enforce preempted state laws. "The injured party does not need § 1983 to vest in him a right to assert that an attempted exercise of jurisdiction or control violates the proper distribution of powers within the federal system." *Golden State*, 493 U.S. at 114 (Kennedy, J., dissenting).

D. Respondents Do Not Need A "Right" In Order To Fall Within The Existing Equitable Cause Of Action

Contrary to petitioners' view (Pet. Br. 22-26, 41-43), the term "right" is not some talismanic, transsubstantive requirement that always must be satisfied to obtain relief in federal court. This Court has held that the word "rights" in Section 1983 is a term of limitation in that particular statute. *See Gonzaga Univ. v. Doe*, 536 U.S. 273, 283 (2002) ("it is only violations of *rights*, not laws, which give rise to § 1983 actions"). By contrast, Section 1331 and the other

statutory bases for the federal courts' power to enjoin state officials from implementing preempted state laws simply "do not limit jurisdiction to those who can show the deprivation of a right, privilege, or immunity secured by federal law within the meaning of § 1983." *Golden State*, 493 U.S. at 119 (Kennedy, J., dissenting).

Further, the Court has held in *Gonzaga*, 536 U.S. at 283, that "the determination of whether a statute confers rights enforceable under § 1983" should be "guide[d]" by the Court's "implied right of action cases" such as *Cort v. Ash*, 422 U.S. 66 (1975). Those cases also require the existence of a "right." But they usually involve a damages claim under a particular federal statute against *private* parties. *See* Br. of *Dominguez* Resp. 35-36 n.17. This case does not involve private defendants.[5]

The Supremacy Clause, by contrast, directly governs only parties acting under color of law. *See Building & Constr. Trades Council v. Associated Builders & Contractors of Mass./R.I., Inc.*, 507 U.S. 218, 229 (1983). Likewise, the federal equitable

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[5] On occasion, the implied private cause of action analysis has been applied to suits brought against government officials. *See Alexander v. Sandoval*, 532 U.S. 275 (2001); *Regents of Univ. of Cal. v. Bakke*, 438 U.S. 265 (1978). In those cases, the federal statute imposed identical duties on recipients of federal funds regardless of whether they were private persons or persons acting under color of law, so the Court's conclusion also decided whether the statute created an implied right of action against private defendants.

cause of action to enjoin implementation of pre-empted state laws runs only against persons acting under color of law. *See Aroostook Band of Micmacs v. Ryan*, 404 F.3d 48, 58 (1st Cir. 2005) (collecting cases); 13D Wright & Miller, *supra* § 3566, at 292 n.70. It is this public-private distinction that has caused the Court consistently to hold that (1) federal courts possess federal-question jurisdiction over preemption claims brought by a private party against a person acting under color of law in his official capacity, *see Verizon*, 535 U.S. at 642; *Ex parte Young*, 209 U.S. at 145; but (2) federal courts do not possess federal-question jurisdiction over preemption claims brought by one private party against another, *see Skelly Oil Co. v. Phillips Petroleum Co.*, 339 U.S. 667, 673-674 (1950); *Louisville & Nashville R.R. v. Mottley*, 211 U.S. 149, 152 (1908).

Nor is this a case like *Astra USA, Inc. v. Santa Clara County*, 131 S. Ct. 1342 (2011), another case against private defendants. There, plaintiffs were attempting to clothe an implied cause of action under the statute as a contract action. This Court rejected that effort because the contracts at issue "simply incorporate statutory obligations" and thus plaintiffs' suit to enforce the contracts against private parties was "in essence a suit to enforce the statute itself." 131 S. Ct. at 1343. By contrast, the "essence" of this suit is *not* to enforce Section 30(A), but to enforce the Supremacy Clause—which bars state officials from implementing any preempted state law.

Moreover, there is a particular irony in petitioners' heavy reliance on *Astra*. The defendants in *Astra* insisted that the contract cause of action was inappropriate because the contract simply incorporated the terms of a Spending Clause statute. Yet here, where respondents seek to enforce the preemptive effect of the federal law, petitioners claim that the federal law is merely a "State's contract with the federal government." Pet. Br. 47.

II. Congress In The Medicaid Act Did Not Preclude Reliance On The Existing Cause Of Action To Enforce The Supremacy Clause

A. Medicaid, Like Other Statutes Enacted Pursuant To The Spending Clause, Is Federal Law And Preempts Contrary State Law Pursuant To The Supremacy Clause

1. Petitioners suggest (Pet. Br. 46-49) that requirements in Spending Clause statutes should be subject to a different Supremacy Clause analysis. But it is settled that federal statutes enacted pursuant to the Spending Clause do preempt.

The cases are legion. For example, a State is preempted from interfering with a recipient's use of federal funds in the manner prescribed by Congress. *See, e.g., Lawrence Cnty. v. Lead-Deadwood Sch. Dist. No. 40-1*, 469 U.S. 256, 258, 269-270 (1985) (holding that state statute governing locality's use of funds "is invalid under the Supremacy Clause" as applied to

federal funds given to locality with intent of vesting it with discretion); *Bennett v. Arkansas*, 485 U.S. 395, 397 (1988) (per curiam) (state statute allowing the State to attach Social Security benefits conflicted with the Social Security Act and was therefore preempted by operation of the Supremacy Clause); *Philpott v. Essex Cnty. Welfare Bd.*, 409 U.S. 413, 417 (1973) ("[b]y reason of the Supremacy Clause," funds derived from Social Security disability benefits are immune from state debt-collection processes even though in private hands). Thus, as the United States explains, "[t]he Act of Congress establishing the joint federal-state program * * * remains binding law with the full force and preemptive authority of federal legislation under the Supremacy Clause." U.S. Amicus Br. 27 n.11.

That preemptive authority applies equally when the State is the recipient of federal funds and disobeys the federal law governing the use of those funds. This Court has so held for more than 40 years. *See* Br. of *Dominguez* Resp. 21-22 n.10. The United States consistently has embraced these holdings. *See* U.S. Amicus Br., *Gonzaga Univ. v. Doe*, No. 01-679, at 18-19 (Feb. 2002); U.S. Br. in Opp., *Haveman v. Westside Mothers*, No. 02-277, at 6-10 (Oct. 2002); U.S. Amicus Br., *Lapides v. Board of Regents of Univ. of Ga. Sys.*, No. 01-298, at 13 (Dec. 2001).

If the Supremacy Clause did not apply in these situations, there would be no justification (in light of the Eleventh Amendment) for permitting suits in federal court against state officials. *See Pennhurst*

State Sch. & Hosp. v. Halderman, 465 U.S. 89, 105 (1984) (Eleventh Amendment bars federal court from adjudicating suits for violations of state law against state officials when federal interest in vindicating Supremacy Clause is lacking). But this Court repeatedly has held that suits to enforce Spending Clause statutes against state officials who are recipients of federal financial assistance are not barred by the Eleventh Amendment. *See, e.g., Virginia Office for Protection & Advocacy v. Stewart*, 131 S. Ct. 1632 (2011) (Developmental Disabilities Act); *Frew ex rel. Frew v. Hawkins*, 540 U.S. 431 (2004) (Medicaid Act); *Edelman v. Jordan*, 415 U.S. 651 (1974) (Aid to the Aged, Blind, and Disabled Act).

2. That Medicaid ultimately involves a State's "voluntary agreement" to participate in the federal program by accepting federal funds does not alter its status as supreme federal law.

Congress has created similar voluntary programs under its Commerce Clause authority, where it offers the State the power to regulate industries consistent with federal law or to abandon the field. *See New York v. United States*, 505 U.S. 144, 167 (1992); *see also FERC v. Mississippi*, 456 U.S. 742 (1982) (Public Utility Regulatory Policies Act of 1978); *Hodel v. Virginia Surface Mining & Recl. Ass'n*, 452 U.S. 264 (1981) (Surface Mining Control and Reclamation Act of 1977). This Court in *New York* explained that this type of Commerce Clause statute is the same as a Spending Clause statute because "the residents of the State retain the ultimate decision as to whether or

not the State will comply. If a State's citizens view federal policy as sufficiently contrary to local interests, they may elect to decline a federal grant. If state residents would prefer their government to devote its attention and resources to problems other than those deemed important by Congress, they may choose to have the Federal Government rather than the State bear the expense of a federally mandated regulatory program." 505 U.S. at 168.

These conditional federal laws are not considered to be any less supreme over state law. *See Verizon*, 535 U.S. 635 (adjudicating preemption claims under the Telecommunications Act of 1996, which permits, but does not require, state public utility commissions to assume regulatory authority over interconnection agreements, 47 U.S.C. § 252(e)(5)). Yet if petitioners' theory about "voluntary" programs were correct, it would follow that these federal laws likewise were not supreme.

Furthermore, drawing a line between Spending Clause statutes and other statutes is not workable. Statutes are not always an exercise of a single power. For example, the federal Solomon Amendment required universities that received federal funds to permit access to military recruiters. While that unquestionably was an exercise of Congress's Spending Power, this Court sustained it as an exercise of Congress's War Power. *See Rumsfeld v. Forum for Academic & Institutional Rights, Inc.*, 547 U.S. 47 (2006). Likewise, a federal statute that prohibited state courts from admitting in civil trials documents

that local governments had created in order to receive certain federal funds was sustained as an exercise of Congress's Commerce Clause power. *See Pierce Cnty., Wash. v. Guillen*, 537 U.S. 129 (2003).

B. In Medicaid, Congress Did Not Create Any Centralized Oversight Scheme That Displaced The Federal Courts' Authority To Enjoin Implementation Of Preempted State Laws

1. Petitioners posit (Pet. Br. 26-27) that Congress decided to "centralize" Medicaid enforcement in HHS. At least three times, however, this Court has addressed and rejected a similar argument.

In *Rosado v. Wyman*, addressing another provision of the Social Security Act, the Court explained that it had "considered and rejected the argument that a federal court is without power to review state welfare provisions or prohibit the use of federal funds by the States in view of the fact that Congress has lodged in the Department of [Health, Education, and Welfare (HEW)] the power to cut off federal funds for noncompliance with statutory requirements." 397 U.S. 397, 420 (1970). In an action under Section 1983, moreover, this Court in *Wilder v. Virginia Hospital Ass'n*, 496 U.S. 498 (1990), again held that the Medicaid administrative oversight mechanism available here—review and approval of state-submitted plans, with withdrawal of funds for non-compliance—did not "evidence[ ] an intent to foreclose a private remedy in the federal courts." *Id.* at 523.

Most recently in *Stewart*, involving another Spending Clause statute, this Court held:

> The fact that the Federal Government can exercise oversight of a federal spending program and even withhold or withdraw funds—which are the chief statutory features respondents point to—does not demonstrate that Congress has "displayed an intent not to provide the 'more complete and more immediate relief' that would otherwise be available under *Ex parte Young*."

131 S. Ct. at 1639 (quoting *Verizon*, 535 U.S. at 647 (quoting *Seminole Tribe v. Florida*, 517 U.S. 44, 75 (1996))).

2. Although this Court in *Gonzaga* relied on the notion of "centralized review" as a ground not to find an enforceable "right," it did so based on a special statutory provision that prohibited the agency from carrying out the enforcement "in any of the regional offices." 536 U.S. at 290 (quoting 20 U.S.C. § 1232g(g)). This Court reasoned that the same Congress that added the centralization provision "due to 'concern that regionalizing the enforcement of [the statute] may lead to multiple interpretations of it'" would not have "intended private suits to be brought before thousands of federal- and state-court judges." *Ibid.*

Medicaid has no such provision. To the contrary, HHS delegates authority to approve plans and plan amendments to its regional offices. *See* 42 C.F.R. § 430.15(b). Those offices are not in fact uniform in

their practices or interpretations. *See* United States Government Accountability Office, *Medicaid Managed Care: CMS's Oversight of States' Rate Setting Needs Improvement*, GAO-10-810 (2010). Furthermore, petitioners' argument cannot be reconciled with their acknowledgements that many parts of Medicaid can be privately enforced. Pet. Br. 42-43, 46-47 n.17. A statute that intended only centralized enforcement would not permit any such suits.

Petitioners note that the Medicaid regulations contemplate that private persons or entities may participate as amicus or parties in administrative hearings. Pet. Br. 7-8. But an administrative hearing can only be triggered if HHS *disapproves* a state plan amendment or *disallows* particular state spending and then the State subsequently challenges HHS's action. Thus, if the regional office approves a state plan amendment (or simply does not act within the 90-day period, *see* 42 U.S.C. § 1396n(f)(2)), there is no hearing in which to participate.

Even in those small subset of cases in which HHS disapproves a state plan amendment and there is an administrative hearing, the regulations allow participation by private persons or entities as parties only "if the issues to be considered at the hearing have caused them injury and their interest is within the zone of interests to be protected by the governing Federal statute." 42 C.F.R. § 430.76(b). Petitioners, of course, claim (Pet. Br. 52 & n.20) that both providers and beneficiaries fall outside this regulation. Thus, despite their pointing to the regulations,

petitioners would offer respondents no forum where they would have an opportunity to be heard or to appeal to court.

And nothing in the statute or regulations permits private parties to trigger an administrative hearing. Thus, this case has none of the statutory protections that this Court found material in *Astra*, where federal law required HHS to develop a "formal dispute resolution procedure," ultimately resulting in federal court review under the APA, to resolve claims by entities that provide medical care for the poor. 131 S. Ct. at 1350.

3. Furthermore, apart from the barriers to private participation, HHS itself does not have effective tools to address rate cuts or other reduction in services. HHS's primary enforcement mechanism is the threat that it will not pay the federal matching share for state spending that does not comply with the Act. That threat has some efficacy when the State's violation is paying too much to providers (or providing services falling outside the scope of Medicaid). HHS simply does not pay the difference between the lower rate the State should have paid and the higher rate it did pay (or HHS refuses to pay for uncovered services). But when, as here, the State *cuts* the rates it pays to providers, there are no discrete payments for HHS to withhold; HHS instead would have to threaten to withdraw federal funding for the State's entire Medicaid program, which has never occurred.

HHS thus possesses no means of ensuring that States will not illegally cut rates. These cases are perfect examples of HHS's impotence. Petitioners implemented the proposed rate cuts months before they even submitted them to HHS for approval. And despite that HHS *disapproved* the cuts (almost two years after they were submitted), petitioners still are paying the disapproved rates except where federal courts have enjoined them from doing so.

A similar situation recently has arisen in Indiana, where the State enacted a law disqualifying a particular provider from receiving Medicaid payments. *See Planned Parenthood of Ind., Inc. v. Commissioner of Ind. State Dep't of Health*, No. 1:11-CV-630, 2011 WL 2532921 (S.D. Ind. June 24, 2011). HHS disapproved the State's plan amendment, *id.* at *10, but the State indicated its intention to enforce the disqualification anyway. HHS's only response was to file an *amicus* brief supporting the provider's private federal suit. Absent a court injunction, Medicaid beneficiaries would have been denied access to certain medical services and the providers would have suffered substantial monetary damages (resulting in lay-offs of employees and closing health centers statewide). *Id.* at *17. There is no evidence that Congress intended such a provider to have no access to federal court in that situation. As the United States itself explained at the certiorari stage, a "system that relies solely on agency review may often be less effective in ensuring the supremacy of federal

law than a system of agency review supplemented by private enforcement." U.S. Cert. Amicus Br. 19.

4. Two other statutes amending Medicaid also reflect Congress's intent that providers should be able to enforce Medicaid provisions, and not just through Section 1983.

First, Congress amended the Medicaid Act in 1975 to provide that any State that did not waive its Eleventh Amendment immunity for "any suit brought against the State or a State officer by or on behalf of any provider of services * * * with respect to the application of [Section 13(D), requiring reasonable rates of reimbursement]" would lose 10% of its Medicaid funds. Pub. L. No. 94-182, § 111(a), 89 Stat. 1051, 1054 (1975).

That amendment appears to respond, in part, to the holding of *Edelman v. Jordan*, 415 U.S. 651 (1974). *Edelman* held that the Eleventh Amendment barred federal courts from awarding retroactive money damages for violations of federal welfare law. Congress enacted the waiver condition because States were "chang[ing] their reimbursement system without receiving HEW approval" and "providers feared that HEW would be slow to determine if State action was legal, and to bring a conformity hearing to cut off Federal funds if they did find the State out of compliance." H.R. Rep. No. 94-1122, at 4 (1976). Congress was concerned that, in the interim, the "State-devised changes in hospital reimbursement would result in a loss of funds" to providers. *Ibid.* The legislative

history noted that although "the providers could sue the State to enjoin action," no retroactive relief would be available absent the waiver. *Ibid.*

Congress repealed this waiver provision in 1976. Pub. L. No. 94-552, 90 Stat. 2540 (1976). The legislative history made clear, however, that Congress did not intend that repeal to "be construed as in any way contravening or constraining the rights of the providers of Medicaid services, the State Medicaid agencies, or the Department to seek prospective, injunctive [relief] in a federal or state judicial forum." S. Rep. No. 94-1240, at 4 (1976). Likewise, HEW stated that "providers can continue, of course, to institute suit for injunctive relief in State or Federal courts, as necessary." H.R. Rep. No. 94-1122, at 7. As this Court concluded, this provision shows that "Congress intended that health care providers be able to sue in federal court for injunctive relief." *Wilder*, 496 U.S. at 516.

Notably, Congress did not limit the waiver, while it was in effect, to Section 1983 suits, but applied it to "any suit." That is relevant because at the time Congress enacted and then repealed this statute, it was not clear whether Section 1983 could be used to enforce rights secured by Medicaid. Although *Edelman* was later characterized in *Maine v. Thiboutot*, 448 U.S. 1 (1980), as a suit under Section 1983, this Court had at the time left open the question what statutes could be enforced through Section 1983, *see Hagans v. Lavine*, 415 U.S. 528, 533 n.5 (1974), and

lower courts and commentators were divided, *see Thiboutot*, 448 U.S. at 29-30 (Powell, J., dissenting).

Two other statutes likewise contemplate that private suits to ensure compliance with Medicaid are not limited to Section 1983. In response to *Suter v. Artist M.*, 503 U.S. 347 (1992), Congress enacted two provisions in 1994 that stated that Medicaid and other provisions of the Social Security Act were not "unenforceable" by private parties simply because the provisions sought to be enforced were identified as components of a state plan. In doing so, Congress again referred expansively to "private actions" brought "to enforce a provision" of the Social Security Act, rather than merely to Section 1983. Pub. L. No. 103-382, § 555, 108 Stat. 3518, 4057 (1994) (codified at 42 U.S.C. § 1320a-2); Pub. L. No. 103-432, § 211, 108 Stat. 4398, 4460 (1994) (codified at 42 U.S.C. § 1320a-10).

C. Congress Did Not Preclude Private Enforcement Of Section 30(A)'s Preemptive Effect

Petitioners seek to characterize Section 30(A) as so amorphous that it has no content to which the Supremacy Clause can attach. Pet. Br. 26, 29-30. But this Court did not grant petitioners' second question presented, which sought review of the meaning of Section 30(A). Given that denial of review, the only question before the Court is whether medical providers and beneficiaries can obtain an injunction to enjoin enforcement of a state law that

conflicts with Section 30(A). In any event, Section 30(A) has substantive content that is well within the judicial ken, and Congress expected private litigation over compliance with Section 30(A).

1. Section 30(A) contains judicially enforceable standards that preempt contrary state laws

Congress first enacted Section 30(A) in 1968. At that time, as petitioners note (Pet. Br. 29-30), it apparently was intended solely as a ceiling on payments. That is, it required state plans to provide for methods and procedures necessary to ensure that "payments * * * are not in excess of reasonable charges consistent with efficiency, economy, and quality of care." Pub. L. No. 90-248, § 237, 81 Stat. 821, 911 (1968).

In 1981, however, Congress removed the "in excess of reasonable charges" language from 30(A), so that the provision required that state plans provide for methods and procedures necessary to ensure that "payments are consistent with efficiency, economy, and quality of care." Pub. L. No. 97-35, § 2174(a), 95 Stat. 357, 809 (1981). The legislative history accompanying the 1981 act indicates that Congress intended the federal courts to be open to suits by beneficiaries or providers:

> The Committee wishes to emphasize that States must continue to operate their programs in conformity with approved State plans. Plan changes that would affect the

> rights of Medicaid beneficiaries or participating providers would be subject to approval of the Secretary, who must confirm that the State's program will continue to be operated in a lawful manner. *Of course, in instances where the States or the Secretary fail to observe these statutory requirements, the courts would be expected to take appropriate remedial action.*

H.R. Rep. No. 97-158, Vol. II, at 301 (1981) (emphasis added).

When Congress next amended Section 30(A) in 1989, it did so to add the requirement that state plans provide for methods and procedures necessary to ensure that payments "are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." Pub. L. No. 101-239, § 6402(a), 103 Stat. 2106, 2260 (1989). In the public law, Congress entitled this amendment: "Codification of adequate payment level provisions." *Ibid.*

The legislative history confirms that Congress added this requirement (which previously existed as an agency regulation) due to concern that beneficiaries were not receiving covered services because physician participation in the Medicaid programs was too low, particularly with respect to obstetricians. H.R. Rep. No. 101-247, at 389-390 (1989). Congress attributed that low participation rate, in turn, to States' failure to maintain adequate provider reimbursement

levels. *Ibid.* In particular, Congress understood that Medicaid expansions also included in the Act "will not have their intended effect if physicians are not willing to treat Medicaid patients." *Id.* at 390. And Congress explained that, "without adequate payment levels, it is simply unrealistic to expect physicians to participate in the program." *Ibid.*

Not surprisingly, then, petitioners conceded in their petitions and in other litigation that Section 30(A) imposes a substantive standard regarding the level of payments. 09-958 Pet. 26, 33 (Section 30(A) "sets some substantive objecti[ves]," including that the rates cannot be so low "as to create an access or quality of care problem for beneficiaries"); 09-1158 Pet. 31; *Orthopaedic Hosp. v. Belshe*, 103 F.3d 1491, 1498 (9th Cir. 1997) ("the Department admitted that the access requirement serves to mandate a minimum payment standard"), cert. denied, 522 U.S. 1044 (1998).

HHS likewise has viewed Section 30(A) as capable of application. It has relied on Section 30(A) to disapprove proposed state rate decreases. *See, e.g.*, 57 Fed. Reg. 917, 918 (Jan. 9, 1992) (disapproving proposed state rate cut because HHS "believes that a forty percent reduction in the State's payment level for physician services would not meet the statutory requirements of section 1902(A)(30) of the Act"). Indeed, every court that addressed the issue prior to *Gonzaga* expressly found Section 30(A) capable of judicial enforcement. *See, e.g., Orthopaedic,* 103 F.3d at 1495-1496; *Visiting Nurse Ass'n of N. Shore, Inc. v.*

Bullen, 93 F.3d 997, 1004 (1st Cir. 1996), cert. denied, 519 U.S. 1114 (1997); *Methodist Hosps., Inc. v. Sullivan*, 91 F.3d 1026, 1028-1029 (7th Cir. 1996); *Arkansas Med. Soc'y Inc. v. Reynolds*, 6 F.3d 519, 523-528 (8th Cir. 1993).

2. *Congress intentionally preserved private enforcement of Section 30(A) even while eliminating the Boren Amendment*

Petitioners point (Pet. Br. 31-33) to Congress's decision in 1997 to repeal the Medicaid Act's Boren Amendment, as well as one sentence in an associated committee report (Pet. Br. 32), to argue that Congress did not want Section 30(A) privately enforced by providers. Of course, the question here is not private enforcement of Section 30(A) alone, but of its preemptive effect through the Supremacy Clause. In any event, petitioners' argument fails on its own terms.

Before 1997, this Court had held in *Wilder* that a different provision of the Medicaid Act, known as the Boren Amendment, could be enforced through Section 1983. At that time, the lower courts were in agreement that Section 30(A) also was privately enforceable through Section 1983. *See*, *supra*, pages 56-57.

In 1997, the National Governors Association urged Congress to repeal both the Boren Amendment and "Boren-like language [in the Medicaid Act] that has exposed states to lawsuits driving up rates for services." *Governors' Perspective on Medicaid*: Hearing Before the S. Comm. on Finance, 105th Cong. 44

(1997). In describing the "Boren-like" provisions, the Governors specifically cited Section 30(A) as one of those provisions, and discussed the then-recent decision in the *Orthopaedic* case out of California. *Ibid.* While Congress did repeal the Boren Amendment, it did not adopt that broader recommendation. Thus, petitioners' reliance on a snippet from a 1997 committee report that described the repeal of the Boren Amendment as precluding enforcement by providers of "any other" provision of Section 1396a, H.R. Rep. No. 105-149, at 591 (1997), does not alter the fact that the text of Section 30(A) was not amended in 1997.[6]

Moreover, other contemporaneous efforts to limit private enforcement of Medicaid also failed. Congress declined to enact proposed bills, reported out of the relevant House and Senate committees in 1996, that expressly would have barred all beneficiary or provider lawsuits in federal court. *See, e.g.*, H.R. Rep. No. 104-651, at 356 (1996) (discussing H.R. 3734, 104th Cong. § 1508(a) (1996), which would have provided that, except for actions by HHS, "no person or entity may bring an action against a State in Federal court based on its failure to comply with any requirement of this title"); S. 1956, 104th Cong.

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[6] Nor did Congress eliminate federal district court jurisdiction over claims involving Medicaid, as it did in the Johnson Act, the Tax Injunction Act, and portions of the Medicare Act, *see Shalala v. Illinois Council on Long Term Care, Inc.*, 529 U.S. 1 (2000); 42 U.S.C. § 1395ww(d)(7).

§ 1508 (1996) (same). And the President vetoed a bill that would have converted Medicaid into a block-grant program and would have abrogated any pending cause of action "which seeks to require a State to establish or maintain minimum payment rates under [Medicaid] or claim which seeks reimbursement for any period before the date of the enactment of this Act based on the alleged failure of the State to comply with [Medicaid]." H.R. 2491, 104th Cong. § 7002(b)(4) (1995); *see also* H.R. Rep. No. 104-350, at 1069 (1995) (Conf. Rep.) ("The bill would remove the existing right for an applicant, beneficiary, provider or health plan to sue a State official under 42 U.S.C. §1983 to require prospective enforcement of the Medicaid statute.").

III. Petitioners' Invocation Of Prudential Standing Is Misplaced And Waived

At the end of their brief, petitioners for the first time suggest that this Court should address questions of "prudential standing." Pet. Br. 49-52. That belated suggestion is both waived and without merit.

A. The claim that respondents lack prudential standing to pursue these actions does not implicate the Court's subject-matter jurisdiction and thus is waivable. *See Craig v. Boren*, 429 U.S. 190, 193-194 (1976). Petitioners waived that argument in these cases by not pressing it in either the court of appeals or in their certiorari petitions.

In neither appeal did petitioners press a zone-of-interests analysis in the court of appeals. In No. 09-958, the court of appeals expressly determined in the

first appeal that petitioners had waived the question of prudential standing by "failing to articulate any argument challenging [respondents'] prudential standing." 09-958 Pet. App. 90a n.17. In the appeal following remand, petitioners accepted that they had waived the issue in the first appeal. 09-55692 Pet. C.A. Br. 32-33. In *California Pharmacists* litigation at issue in No. 09-1158, petitioners did not raise prudential standing in the court of appeals in their "Statement of the Issues," and simply dropped a footnote asserting that respondents lacked prudential standing because they "have no rights under the federal law they seek to enforce." 09-55532 Pet. C.A. Br. 22-23 n.10.

And, as petitioners admit (Pet. Br. 52 n.20), in neither case did they argue that the respondent beneficiaries (as opposed to providers) were not within the zone of interests.

In this Court, standing is not mentioned in any of the three petitions, three reply briefs, and two supplemental briefs filed by petitioners filed at the certiorari stage. The focus of those filings was the existence of a cause of action, not justiciability doctrines such as prudential standing. "[T]he question whether a plaintiff states a claim for relief 'goes to the merits' in the typical case, not the justiciability of a dispute." *Bond*, 131 S. Ct. at 2362.

B. In any event, respondents possess prudential standing. They are not seeking to enforce the rights of the United States, nor of the public at large.

Instead, they seek to enforce the Supremacy Clause. That Clause (like other federalism provisions governing the relationship between the National Government and the States) was intended to protect individuals by preventing one sovereign from encroachment into its proper scope of authority. *See McCulloch v. Maryland*, 17 U.S. 316, 427-432 (1819); *Golden State*, 493 U.S. at 455 (Kennedy, J., dissenting) (describing the Supremacy Clause's "protection of the federal structure").

Just as a person has prudential standing to argue that "[t]he public policy of the Commonwealth of Pennsylvania, enacted in its capacity as sovereign, has been displaced by that of the National Government," *Bond*, 131 S. Ct. at 2366, a person has prudential standing to argue that a law enacted by a State has been displaced by the National Government. In both circumstances, "[a]n individual has a direct interest in objecting to laws that upset the constitutional balance between the National Government and the States when the enforcement of those laws causes injury that is concrete, particular, and redressable." *Id.* at 2364.

Further, to the extent relevant, Section 30(A) itself was enacted to ensure that beneficiaries received medical services by creating sufficient incentives for doctors to provide services to Medicaid patients. *See, supra*, pages 55-56. As beneficiaries of medical services and the providers of those services, both have a direct interest in how much the providers are paid. Indeed, the facts of these cases show that the rate cuts would have a significant and immediate

detrimental impact on both beneficiaries and providers. *See, supra*, pages 8-13. Both certainly have interests "arguably [sought] to be protected by the statutes." *Thompson v. North Am. Stainless, LP*, 131 S. Ct. 863, 870 (2011) (quoting *National Credit Union Admin. v. First Nat'l Bank & Trust Co.*, 522 U.S. 479, 495 (1998)).

Taken to its logical conclusion, petitioners apparently believe that neither providers nor beneficiaries could challenge any HHS regulations to implement Section 30(A) under the Administrative Procedure Act because they do not fall within the zone of interests. That view—that respondents cannot be parties in HHS administrative hearings and cannot appeal adverse HHS decisions or regulations—would be a nightmare for those who rely on Medicaid to provide a medical safety net.

CONCLUSION

For the reasons set forth above, the judgments of the court of appeals should be affirmed.

Respectfully submitted,

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In the Supreme Court of the United States

TOBY DOUGLAS, DIRECTOR OF CALIFORNIA DEPARTMENT OF HEALTH SERVICES, *Petitioner*,

v.

INDEPENDENT LIVING CENTER OF SOUTHERN CALIFORNIA, INC., *et al.*, *Respondents*.

TOBY DOUGLAS, DIRECTOR OF CALIFORNIA DEPARTMENT OF HEALTH SERVICES, *et al.*, *Petitioners*,

v.

CALIFORNIA PHARMACISTS ASSOCIATION, *et al.*, *Respondents*.

TOBY DOUGLAS, DIRECTOR OF CALIFORNIA DEPARTMENT OF HEALTH SERVICES, *Petitioner*,

v.

SANTA ROSA MEMORIAL HOSPITAL, *et al.*, *Respondents*.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF FOR *DOMINGUEZ* RESPONDENTS IN CASE NO. 09-1158

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QUESTION PRESENTED

Whether Medicaid recipients and providers who face injury from a state statute that conflicts with 42 U.S.C. §1396a(a)(30)(A) may maintain a cause of action for injunctive relief under the Supremacy Clause to prohibit state officials from implementing the preempted state statute.

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INTRODUCTION

The California Legislature adopted a statute that would reduce the State's contribution to the rates used by the State's Medicaid program in paying for in-home supportive services. In the *Dominguez* case, a group of Medicaid beneficiaries and providers who faced imminent injury sought injunctive relief against this statute. The District Court entered a prospective injunction to prevent California officials from implementing the new statute on the ground that the statute conflicts with 42 U.S.C. §1396a(a)(30)(A) ("30(A)") and therefore is preempted under the Supremacy Clause. In this regard, the *Dominguez* case is structurally indistinguishable from *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85 (1983), *Foster v. Love*, 522 U.S. 67 (1997), and countless other cases since the founding, in which the federal courts granted prospective injunctive relief to prevent state officials from implementing state laws that are preempted under the Supremacy Clause and would cause injury to plaintiffs with Article III standing.

California devotes much of its Brief to defending the premise that there is no such thing as a "cause of action" for injunctive relief that arises directly under the Supremacy Clause. Based on that premise, California argues that the *Dominguez* plaintiffs' plea for injunctive relief should not have been heard, because the pertinent federal statute does not give them a "right" enforceable through 42 U.S.C. §1983 ("§1983") under the *Gonzaga University v. Doe*, 536 U.S. 273 (2002) analysis, or an implied statutory cause of action under the *Cort v. Ash*, 422 U.S. 66 (1975) analysis. Pet. Br. 14-15, 20-23. But accepting California's premise would require elimination of a *constitutional* cause of action available in the federal courts since the inception of the Republic.

Even California ultimately acknowledges that this Court has authorized injunctive relief in numerous actions arising directly under the Supremacy Clause. Pet. Br. 43-44. And this Court's Supremacy Clause cases, which include actions like this one, are firmly rooted in the traditional equitable authority of the federal courts and are necessary to secure the constitutional balance of powers between the federal and state governments. The Constitution and Congress have vested the federal courts with equity jurisdiction, and the courts have a duty to exercise that jurisdiction to enjoin preempted state laws.

STATEMENT OF THE CASE

The *Dominguez* Respondents were the plaintiffs in one of the three cases covered by the Petition in No. 09-1158. The facts and procedural history in California's Statement of the Case are correct as they relate to the *Dominguez* case, with a few exceptions, set forth in the accompanying footnote.[1] Additionally: California does not explain that, after the District Court's preliminary injunction, the California Legislature delayed the effective date of the statute challenged in *Dominguez* until the later of July 1,

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[1] First, California asserts that among the purposes of the challenged statutes was "increasing the efficiency of the State's Medicaid program." Pet. Br. 5. But it was not disputed below that the sole purpose of the statute challenged in *Dominguez* was to address the State's budget deficit. 2009 Cal. Leg. Serv. 3rd Ex. Sess. Ch. 13 (S.B. 6), §13. Second, Respondents disagree that the statute reducing the State's maximum contribution to provider payments left the methodology for determining payments unchanged. Pet. Br. 9. Third, the Court of Appeals panel that issued the decisions in Cases 09-1158 and 09-958 was comprised of two of the same judges as the *Independent Living Center of Southern California v. Shewry*, 543 F.3d 1050 (9th Cir. 2008) (*Independent Living I*) panel but the third judge was not the same. Pet. Br. 14 n.5. Finally, California includes argument within its Statement of the Case that the *Dominguez* Respondents address in the body of this brief. *E.g.*, Pet. Br. 5-6.

2012 or the date that a court renders a final judgment upholding its validity. *See* Cal. Welf. & Inst. Code §12306.1(d)(7)(B).

SUMMARY OF ARGUMENT

1. The *Dominguez* plaintiffs faced injury from the implementation of a state statute that conflicts with 42 U.S.C. §1396a(a)(30)(A) and therefore is invalid under the Supremacy Clause. They obtained a prospective injunction to prevent implementation of the preempted state law. As such, their suit is structurally indistinguishable from *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85 (1983), *Foster v. Love*, 522 U.S. 67 (1997), and countless cases decided by the federal courts since the founding. These cases arise under the Supremacy Clause and are grounded in the traditional equitable powers of the federal courts.

As amicus United States recognizes, the availability of federal court suits for prospective injunctive relief against state statutes preempted by federal law under the Supremacy Clause is "well established" and "serves an important purpose" by "appropriately vindicat[ing] the supremacy of federal law." U.S. Br. 20-21 & n.7. This Court recognized the viability of such suits in *Osborn v. Bank of the United States*, 22 U.S. (9 Wheat.) 738 (1824), reaffirmed their viability in *Shaw*, 463 U.S. at 96 n.14, and has decided on the merits at least 61 such cases, including many in just the past few terms. *See* Appendix (listing cases). As Justice Kennedy explained in *Golden State Transit Corp. v. City of Los Angeles*, 493 U.S. 103 (1989), "plaintiffs may vindicate . . . pre-emption claims by seeking declaratory and equitable relief in the federal district courts through their powers under federal jurisdictional statutes." *Id.* at 119 (Kennedy, J., dissenting).

These suits fall within a broader category of cases authorized by the courts' traditional authority to grant

equitable relief – as opposed to damages – to enforce the Constitution. The Supremacy Clause must be read in light of the founding-era understanding that courts with equity jurisdiction could provide individuals equitable relief for injuries caused by public officials acting in excess of their legal authority.

2. State laws that conflict with the Medicaid Act are preempted under the Supremacy Clause and therefore may be enjoined by the federal courts. While the Court has used a contract analogy as an interpretative aid in some Spending Clause cases, it has always recognized that statutes adopted under Congress' spending powers are "Laws of the United States" for purposes of the Supremacy Clause. U.S. Const., Art VI, cl. 2. Consequently, the Court repeatedly has struck down state laws preempted by Spending Clause statutes.

The Court long ago rejected California's argument that the Supremacy Clause is inapplicable when state participation in a Spending Clause program is voluntary. The Court also long ago rejected California's argument that the presence of a withholding-of-funds remedy as part of Spending Clause programs established by the Social Security Act (which include Medicaid programs) demonstrates that Congress intended to strip the courts of their traditional jurisdiction to enjoin implementation of state laws that are preempted under the Supremacy Clause. The Court found "not the slightest indication" of congressional intent to do so. *Rosado v. Wyman*, 397 U.S. 397, 420, 422 (1970). Congress has ratified that interpretation of the pertinent statutes. And amicus United States pointedly "is *not* suggesting that Congress has displayed an intent not to provide the more complete and more immediate relief that would otherwise be available under *Ex parte Young*." U.S. Br. 32 n.12 (emphasis added; internal quotations and citations omitted).

3. Precedents regarding whether statutes create individual "rights" enforceable under 42 U.S.C. §1983 are not relevant to suits for prospective injunctive relief under the Supremacy Clause. Those §1983 cases deal with an issue of statutory interpretation and a statute that provides for compensatory and punitive damages. The Court's precedents make clear that the unavailability of a claim under §1983 does not mean that the federal courts cannot grant injunctive relief to enforce the Constitution.

Likewise, jurisprudence regarding implied statutory rights of action does not govern this case. Those cases are about congressional intent to authorize a statutory cause of action, which generally would allow damages suits against private defendants for private actions. Such claims are entirely divorced from claims for equitable relief directly under the Supremacy Clause to prevent implementation by public officials of preempted state laws.

4. California proposes that the Court limit the availability of Supremacy Clause injunction actions to situations in which the plaintiff effectively asserts an "anticipatory defense" to a state regulatory action. But that proposed limitation on the authority of the federal courts is not supported by history or precedent.

The historical practice at the founding did not limit equitable relief to plaintiffs seeking to enjoin actions at law or to situations in which an enforcement action could be brought against the plaintiff. And, as a matter of precedent, this Court has authorized Supremacy Clause preemption injunctions where the plaintiff faced no threat of enforcement or regulatory proceedings. *See, e.g.*, *Crosby v. National Foreign Trade Council*, 530 U.S. 363, 366 (2000); *Foster v. Love*, 522 U.S. 67, 68-69, 74 (1997); *Wisconsin Dep't of Indus., Labor & Human Relations v. Gould Inc.*, 475 U.S. 282, 283-84 & nn.1-2

(1986). Moreover, the availability of private litigation to vindicate the supremacy of federal law is *more* important when no state enforcement action could be brought.

The United States posits that cases like *Crosby* are permissible Supremacy Clause suits only because they involve, "in effect, [plaintiffs] asserting an immunity" from what were, "in essence, state regulatory requirements" directed at their "primary conduct." U.S. Br. 22-24 & nn.8-9. But that theory finds no support in this Court's cases, lacks any theoretical or historical basis, and fails to explain cases like *Foster*, 522 U.S. at 68-69, 74 (state primary law preempted by federal statute setting date for elections), as well as numerous other decisions in which this Court has decided preemption injunction claims involving disputes over government benefits, in which no such "in essence" regulation argument could be made.

The sum of the matter is that "[r]emedies designed to end a continuing violation of federal law are necessary to vindicate the federal interest in assuring the supremacy of that law." *Green v. Mansour*, 474 U.S. 64, 68 (1985). That interest is as present in Supremacy Clause injunction actions like this one as in the actions California would allow.

5. Finally, California waived its prudential standing argument by not challenging the *Dominguez* plaintiffs' prudential standing below or raising the issue in its certiorari petition. In any event, the argument is meritless, because the *Dominguez* plaintiffs are Medicaid providers and beneficiaries who are injured by the Supremacy Clause violation at issue and easily meet the prudential standing test.

ARGUMENT

I. A PLAINTIFF INJURED BY A STATE LAW PREEMPTED UNDER THE SUPREMACY CLAUSE MAY OBTAIN A FEDERAL COURT INJUNCTION TO PROHIBIT IMPLEMENTATION OF THE LAW

A. The federal courts have always been open to suits by private litigants seeking to enjoin the implementation of unconstitutional state laws, including laws preempted under the Supremacy Clause, so long as jurisdiction is present

Actions seeking prospective injunctive relief to enforce the Supremacy Clause are not a new phenomenon. As the United States as amicus recognizes, the availability of suits for injunctive relief against state laws preempted by federal law under the Supremacy Clause is "well established," "serves an important purpose" by "appropriately vindicat[ing] the supremacy of federal law," and is rooted in the federal courts' traditional equitable powers to grant injunctive relief. U.S. Br. 20-21 & n.7.

This Court held in *Osborn v. Bank of the United States*, 22 U.S. (9 Wheat.) 738 (1824), that "[i]t was proper" for a federal court to issue an injunction prohibiting a state official from implementing a state law (in that case a tax) that was "repugnant to a law of the United States, made in pursuance of the constitution," (there the statute creating the Bank of the United States), explaining that the case was properly "cognizable in a Court of equity." *Id.* at 839, 859, 865, 867-68. In *Gilman v. City of Philadelphia*, 70 U.S. (3 Wall.) 713, 719, 721-24 (1865), the Court decided on the merits a suit to enjoin a state law authorizing construction of a bridge allegedly "repugnant to the Constitution and laws of the United States," including a federal statute that "authorize[d] vessels enrolled and licensed according to its provisions to engage in the

coasting trade." *Id.* at 724. The Court rejected the argument that only the federal government could bring the suit, explaining that "wherever a public nuisance is productive of a specific injury to an individual, . . . if the injury would be irreparable, . . . a court of equity will interpose by injunction." *Id.* at 722 (citing *Pennsylvania v. Wheeling & Belmont Bridge Co.*, 59 U.S. (18 How.) 421 (1855) (*Wheeling Bridge II*)).[2]

This Court reaffirmed the federal courts' authority to hear such cases in *Shaw v. Delta Airlines, Inc.*, 463 U.S. 85 (1983), explaining that "[a] plaintiff who seeks injunctive relief from state regulation, on the ground that such regulation is pre-empted by a federal statute which, by virtue of the Supremacy Clause of the Constitution, must prevail, . . . presents a federal question which the federal courts have jurisdiction under 28 U.S.C. §1331 to resolve." *Id.* at 96 n.14.

Though *Shaw* spoke in terms of "jurisdiction" without expressly referring to the plaintiffs' "cause of action," the Court's resolution of the case went beyond a recognition of subject matter jurisdiction. Unlike in *Bell v. Hood*, 327 U.S. 678, 681-85 (1946), the Court in *Shaw* did not simply conclude that the district court had jurisdiction, but rather it went on to resolve the case on the merits and strike down the preempted state law. The Court noted that it "frequently has resolved pre-emption disputes in a similar jurisdictional posture." 463 U.S. at 96 n.14 (citing cases).

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[2] Congress conferred general federal question jurisdiction on the federal courts in the Judiciary Act of 1875, ch. 137, §1, 18 Stat. 470. Earlier, jurisdiction was generally limited to cases in diversity, with some narrow exceptions. *See* Judiciary Act of 1789, ch. 20, §11, 1 Stat. 73. During that time, injunction actions to enforce the Supremacy Clause were available where the federal courts had jurisdiction over the case. *See, e.g.*, *Osborn*, 22 U.S at 817-18 (jurisdiction conferred by statute incorporating Bank of the United States); *Gilman*, 70 U.S. at 719, 721 (diversity).

Thus, as Justice Kennedy correctly explained in *Golden State Transit Corp. v. City of Los Angeles*, 493 U.S. 103 (1989), "plaintiffs may vindicate . . . pre-emption claims by seeking declaratory and equitable relief in the federal district courts through their powers under federal jurisdictional statutes." *Id.* at 119 (Kennedy, J., dissenting). This Court also pointed out in *Lawrence County v. Lead-Deadwood School District*, 469 U.S. 256 (1985), that a claim that a state law is preempted by a federal statute adopted under Congress' Spending Clause authority states a federal claim under the same rationale applied in *Shaw*. 469 U.S. at 259 n.6.

The cases listed in the accompanying Appendix reflect that this Court has decided at least 61 cases brought in federal court directly under the Supremacy Clause for injunctive or declaratory relief against preempted state laws, including several in just the past few terms. *See, e.g., Chamber of Commerce of the U.S. v. Whiting*, 131 S.Ct. 1968, 1977, 1987 (2011) (reaching merits in injunctive suit by business and civil rights groups alleging state law preempted by federal immigration law); *Chamber of Commerce of the U.S. v. Brown*, 554 U.S. 60, 64-66 (2008) (holding state statute preempted by National Labor Relations Act); *Rowe v. New Hampshire Motor Transport Ass'n*, 552 U.S. 364, 369 (2008) (holding state statute preempted by Federal Aviation Administration Authorization Act).[3] Countless such cases have been heard by the lower federal courts without reaching this

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[3] Based on our review, the preemption claims in the cases listed in the Appendix were not brought under 42 U.S.C. §1983; nor does it appear that the federal statutes involved contain the type of "rights-creating" language necessary to satisfy the test set forth in *Gonzaga University v. Doe*, 536 U.S. 273 (2002). *See infra* at 38-39. The Appendix does not contain numerous additional cases decided by this Court in which Supremacy Clause injunction claims were initially brought in state court. *See infra* at 10.

Court. This Court has also decided on the merits numerous federal Supremacy Clause injunction claims brought initially in the state courts. *See, e.g., Mid-Con Freight Sys., Inc. v. Michigan Pub. Serv. Comm'n*, 545 U.S. 440, 442, 445 (2005); *Castle v. Hayes Freight Lines*, 348 U.S. 61, 62-63 (1954); *Coyle v. Smith*, 221 U.S. 559, 562-65 (1911); *Boyer v. Boyer*, 113 U.S. 689, 690-91 (1885).

These actions fall within a broader category of cases granting equitable relief, which "has long been recognized as the proper means for preventing entities from acting unconstitutionally." *Free Enterprise Fund v. Public Co. Accounting Oversight Bd.*, 130 S.Ct. 3138, 3151 n.2 (2010) (quoting *Correctional Servs. Corp. v. Malesko*, 534 U.S. 61, 74 (2001)).

While this Court has been reluctant to recognize new causes of action to seek *damages* for constitutional violations, it has repeatedly stressed the important distinction between damages and injunctive relief, reaffirming the traditional availability of the latter in suits to enforce the Constitution. *See, e.g., United States v. Stanley*, 483 U.S. 669, 683 (1987) (claims for injunctive relief, unlike claims for money damages, are "designed to halt or prevent the constitutional violation . . . [, seek] traditional forms of relief, and '[do] not ask the Court to imply a new cause of action.'") (quoting *Chappell v. Wallace*, 462 U.S. 296, 305 n.2 (1983)); *Malesko*, 534 U.S. at 74; *cf. Bivens v. Six Unknown Named Agents of Federal Bureau of Narcotics*, 403 U.S. 388, 404 (1971) (recognizing "presumed availability of federal equitable relief against threatened invasions of constitutional interests"). The distinction between suits for damages and those seeking equitable relief reflects the historical grounding of the latter in the federal courts' traditional equitable powers. *See Pierce v. Society of Sisters*, 268 U.S. 510, 536 (1925) ("Prevention of impending injury by unlawful action is a well-recognized function of courts of equity").

Thus, injured individuals have since the founding been able to seek prohibitory injunctions against state officials in the federal courts to prevent implementation of unconstitutional laws, so long as the case otherwise fell within the federal courts' jurisdiction. *See, e.g., Osborn*, 22 U.S. at 868, 870 (state act "repugnant" to law constituting Bank of the United States was "unconstitutional and void"); *Dodge v. Woolsey*, 59 U.S. 331, 336, 339, 360-61 (1855) (state law violated contracts clause); *Ex parte Young*, 209 U.S. 123, 144 (1908) (state law violated due process); *Pierce*, 268 U.S. at 534-36 (state law contrary to Fourteenth Amendment liberty interests).

B. Injunction actions to enforce the Supremacy Clause are supported by the founding era understanding that courts with equitable jurisdiction would have authority to prevent injury caused by constitutional violations

Not only are injunctions to enforce the Supremacy Clause not a new phenomenon, but they are firmly grounded in the founding generation's understanding of equity jurisdiction. California's ahistorical approach ignores the background against which the Supremacy Clause and the other provisions of the Constitution were adopted.[4]

The framers drafted the Constitution, and the founding generation ratified it, within an existing jurisprudential framework that defined judicial authority and determined which cases courts would properly entertain. Operating within this framework, the framers and ratifiers would

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[4] Likewise, amicus National Governors Association offers an account of the colonial practice of appeals to the Privy Council in England, but says nothing about types of cases the founding generation would have understood to be cognizable in courts of equity. Nat'l Govs. Ass'n Br. 4-13.

have expected that a court with equitable jurisdiction could provide injured individuals relief for injuries caused by constitutional violations, without requiring that the plaintiff point to a statute creating a specific "cause of action." Whatever the Court's modern jurisprudence may say about the viability of suits seeking redress for purely statutory violations, the availability of suits to enforce the *Constitution* through equitable relief stems from this founding era understanding of the authority of courts of equity.

1. While common law courts in the eighteenth century would hear cases only where the plaintiff's injuries conformed to a recognized form of action, F.W. Maitland, *Equity, Also the Forms of Action at Common Law: Two Courses of Lectures* 296-300 (1929 ed.), equity courts ("chancery courts") could hear cases and provide relief for injuries that did not conform to the set common law forms. John Mitford, *A Treatise on the Pleadings in Suits in the Court of Chancery* 7-9 (2d ed. 1787) ("Mitford").[5] To be entitled to equitable relief, plaintiffs had to show "that the acts complained of are contrary to equity, and tend to the *injury* of the complainants, and that they have no remedy, or not a complete remedy, without the assistance of the court." *Id.* at 43 (emphasis added).

In accord with this basic rule, at the time of the founding, suits in equity against public officials were available to prevent injury caused by actions taken in excess of the officials' legally conferred authority. *See, e.g., Hughes v. Trustees of Morden College*, 1 Vesey 188 (Ch. 1748) (suit in English High Court of Chancery against turnpike com-

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[5] "Prior to the Revolution, courts of chancery had existed in some shape or other in every one of the thirteen colonies." Solon Dyke Wilson, *Courts of Chancery in the American Colonies*, in 2 *Select Essays in Anglo-American Legal History* 779, 779 (1907).

missioners).[6] Cases from both America and England decided after the founding confirm the settled principle that "relief may be given in a court of equity . . . to prevent an injurious act by a public officer, for which the law might give no adequate redress." *Carroll v. Sanford*, 44 U.S. (3 How.) 441, 463 (1845); *see, e.g.*, *Belknap v. Belknap*, 2 Johns. Ch. Rep. 463, 473 (N.Y. Ch. 1817) (based on "well settled" "jurisdiction of chancery," if commissioners "exceeded their powers, . . . chancery would restrain them by injunction, and keep them strictly within the limits of their power") (citing cases); *Baring v. Erdman*, 2 F. Cas. 784, 786 (No. 981) (C.C.E.D.Pa. 1834) (where acts of public officials "transcend the authority conferred on them by law," they are subject to control by injunction to prevent "irreparable injury"); *Frewin v. Lewis*, 4 Mylne & Craig 249, 254-55 (Ch. 1838) (equity court will prevent injury by enjoining public officials from acting "beyond the line of their authority"). Applying this principle, the founding generation understood that suits would be available in courts with equity jurisdiction to enjoin public officials from exceeding the limits on their authority set in the Constitution. The Supremacy Clause is, of course, one such limit.

2. It would be contrary to the understanding at the founding to limit suits to enforce the Constitution to circumstances in which a statute provides the plaintiff a "right" as that term is used in the context of this Court's modern 42 U.S.C. §1983 and implied-statutory-right-of-

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[6] The authority of courts of equity to enjoin public officials from causing injury has ancient roots. *See, e.g.*, *Hall v. Mason*, Callis, 262 (1621) (suit in equity against Commissioners of Sewers), discussed in *The Reading of the Famous and Learned Robert Callis, Esq. Upon the Statute of Sewers* 262 (4th ed. 1824); *Box v. Allen*, 1 Dickens 49 (Ch. 1727) (Commissioners of Sewers); *Pilkington v. City of York*, 1 Dickens 84 (Ch. 1742) (city).

action jurisprudence. Indeed, in the founding era a plaintiff in equity did not have to show that a statute provided a "right" even as the term was understood then (i.e., a legal interest recognized by the common law courts), nor did a plaintiff have to show a right to proceed at common law against the defendant. Rather, the founding generation understood the question whether a party could bring suit in equity to redress a particular injury to be a question about the scope of the court's "jurisdiction." *See* Mitford at 103-04 (discussing availability of equitable relief in terms of "jurisdiction"); *id.* at 120-21 (to support bill in equity where plaintiff suffers injury and common law provides no remedy or recognizes no right at all, plaintiff must "sh[o]w that the subject of the suit is such upon which a court of equity will assume jurisdiction").

Equity courts had jurisdiction to exercise power in a variety of contexts, including both "where the principles of law by which the ordinary courts are guided give a right, but the powers of those courts are not sufficient to afford a complete remedy, or their modes of proceeding are inadequate to the purpose," *and* "where the principles of law by which the ordinary courts are guided *give no right*, but upon the principles of universal justice the inference of the judicial power is necessary to prevent a wrong, and the positive law is silent." Mitford at 103-04 (emphasis added); *see* 1 Joseph Story, *Equity Jurisprudence* §29 (1836) ("Story"); 1 John Norton Pomeroy, *Equity Jurisprudence* §424 (1881) ("Pomeroy"). The question was whether the defendant's unlawful acts unjustly "tend to the *injury* of the complainant." Mitford at 43 (emphasis added). Where a court of equity exercised its authority, it would issue injunctions "to restrain the defendant from . . . doing any injurious act." *Id.* at 46; *see also* 3 Matthew Bacon, *A New Abridgement of the Law* 172 (6th ed. 1743) (defining injunction as "a prohibitory Writ, restraining a Person from committing or

doing a Thing which appears to be against Equity and Conscience") (citing cases).[7]

While the common law courts "viewed an action as a test of a judicial right asserted," the equity courts "viewed a suit from the standpoint of the wrong presented for investigation." Charles D. Frierson, *A Certain Fundamental Difference in Viewpoint Between Law and Equity as Illustrated by Two Maxims*, in *Report of the Proceedings of the Bar Association of Arkansas* 130, 131 (1914-1915). Equity jurisdiction was exercised upon the ground "that a wrong [wa]s done, for which there [wa]s no plain, adequate, and complete remedy in the Courts of Common Law." 1 Story §49. By the time of the founding, this basic guiding equitable principle had long been established. As but one example, in a case decided in 1491, Chancellor Morton, Archbishop of Canterbury, responded to an argument that he was without jurisdiction because upon the facts the common law admitted no right and gave no remedy, by stating: "It is so in all cases where there is no remedy at the common law and no right, and yet a good remedy in equity." Year Book of Henry VII, folio 12 (quoted in 1 Pomeroy §50); *see also* 1 Pomeroy §423.

3. The Constitution authorized the creation of federal courts that would have all the traditional equitable powers by declaring in Article III that the judicial power of the United States extends "to all cases, in Law and Equity." The first Congress then delineated the initial set of cases in

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[7] Plaintiffs whose claims sounded in equity may have lost *on the merits* if they did not have an "[i]nterest in the subject of the suit," for example "where a plaintiff claimed under a will, and it was apparent upon the construction of the will that he had no title," Mitford at 136 (citing *Brownsword v. Edwards*, 2 Vesey 243, 247 (Ch. 1750)), or if they did not have "proper title to institute a suit concerning" the subject matter, for example where an executor had not properly proved the validity of the will of his testator. Mitford at 137-38 (citing cases).

which the federal courts could exercise their equitable authority by granting the courts diversity jurisdiction over suits "in equity" in the Judiciary Act of 1789, ch. 20, §11, 1 Stat. 73, 78. In doing so, the founding Congress intended the federal courts to apply the principles and provide the remedies available in the High Court of Chancery in England. *See Robinson v. Campbell*, 16 U.S. (3 Wheat) 212, 222-23 (1818); *Boyle v. Zacharie*, 31 U.S. (6 Pet.) 648, 658 (1832); *see also* 1 Story §57. In *Pennsylvania v. Wheeling & Belmont Bridge Co.*, 54 U.S. (13 How.) 518 (1851) (*Wheeling Bridge I*), the Court summarized the rule, which had been observed in the federal courts "since the organization of the government," that in equity suits "[t]he usages of the High Court of Chancery in England, whenever the jurisdiction is exercised, govern the proceedings," and "there is no other limitation to the exercise of a chancery jurisdiction by these courts," except limitations in statutes defining federal court jurisdiction generally. *Id.* at 563.

Early practices of both federal and state courts reflect that traditional equitable principles authorized suits by individuals threatened with injury for equitable relief against the operation of unconstitutional state laws, where no adequate remedy was available at law. *See, e.g, Osborn*, 22 U.S. at 845 (holding case to be one "in which a Court of equity ought to interpose"); *State v. Wilson*, 11 U.S. (7 Cranch) 164, 166, 166-67 (1812) (state court suit to prevent operation of state law in conflict with federal constitution); *cf. Weston v. City Council of Charleston*, 27 U.S. 449, 450 (1829) (state court prohibition action); *Lindsay v. East Bay Street Comm'rs*, 2 Bay 38 (S.C.Const. 1796) (same).[8]

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[8] State courts' early practice of entertaining injunctive suits to prevent implementation of state laws under state constitutions reflects the same basic understanding of traditional equitable principles. *See, e.g., Turpin v. Locket*, 10 Va. (6 Call) 113 (1804); *Bradley v. Commissioners*, 21 Tenn. 428 (1841); *Galloway v. Jenkins*, 63 N.C. 147 (1869); *Graham v. Horton*, 6 Kan. 343 (1870).

Suits to enforce the Constitution through equitable relief proliferated after Congress granted general federal question jurisdiction to the federal courts in all cases "in equity" in the Judiciary Act of 1875, ch. 137, §1, 18 Stat. 470. *See, e.g., Greenwood v. Union Freight R. Co.*, 105 U.S. 13, 14, 16-17 (1881); *Poindexter v. Greenhow*, 114 U.S. 270, 275 (1885); *Allen v. Baltimore & O.R. Co.*, 114 U.S. 311, 311-13 (1885); *Pennoyer v. McConnaughy*, 140 U.S. 1, 8, 25 (1891); *Ex parte Tyler*, 149 U. S. 164, 187-88 (1893); *Reagan v. Farmers' Loan & Trust Co.*, 154 U.S. 362, 393, 399 (1894); *Scott v. Donald*, 165 U.S. 107, 108-09, 112 (1897); *Smyth v. Ames*, 169 U.S. 466, 469-70, 476-77, 517, 522-23 (1898); *see also Philadelphia Co. v. Stimson*, 223 U.S. 605, 620 (1912) (citing numerous cases where "state officers seeking to enforce unconstitutional enactments" were subject to "injunction process" to prevent "injury threatened by [officers'] illegal action"). This Court reaffirmed the viability of such suits in *Ex parte Young*, 209 U.S. 123, 149, 167 (1908).

C. Injunction actions to enforce the Supremacy Clause have correctly been treated the same as suits seeking to enforce other constitutional provisions

This Court has never distinguished the availability of suits seeking injunctive relief to enforce the Supremacy Clause from suits seeking such relief to enforce other provisions of the Constitution. Nor is there a reasoned basis for such a distinction.

The Supremacy Clause declares that both "[t]his Constitution, and the Laws of the United States which shall be made in Pursuance thereof . . . shall be the supreme Law of the Land." U.S. Const., Art. VI, cl.2. In their relation to state laws, the Supremacy Clause places the Constitution and laws of the United States on equal footing. There is no structural or textual reason to distinguish between them for

purposes of injunctive suits to prevent implementation of invalid state laws. A state official violates the federal Constitution when he enforces a state statute that conflicts with either source of supreme law.

Moreover, contrary to California's contention (Pet. Br. 35-36), a suit to enforce the Supremacy Clause *is* a suit that arises directly under the Constitution. *See Douglas v. Seacoast Prods., Inc.*, 431 U.S. 265, 272 (1977) (preemption "claim is basically constitutional in nature, deriving its force from the operation of the Supremacy Clause"). A state law "cannot be constitutional" if "it conflicts with a law of congress made in pursuance of the constitution, and which makes it the supreme law of the land." *Dobbins v. Commissioners of Erie County*, 41 U.S. 435, 450 (1842), *overruled on other grounds by Graves v. New York ex rel. O'Keefe*, 306 U.S. 466, 481-82, 486 (1939); *see McCulloch v. Maryland*, 17 U.S. (4 Wheat.) 316, 436 (1819) (holding that "the unavoidable consequence of that supremacy which the constitution has declared" is that state laws that act "to retard, impede, burden, or in any manner control, the operations of the constitutional laws enacted by congress" are "unconstitutional and void"); *Osborn*, 22 U.S. at 868, 870 (state law "repugnant to a law of the United States" is "unconstitutional and void").[9]

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[9] *Swift & Co. v. Wickham*, 382 U.S. 111 (1965), is not to the contrary. The Court there dealt with a pure issue of statutory interpretation, *i.e.*, whether Congress meant the jurisdiction of three-judge district courts, which was limited to situations where a state statute was challenged "'upon the ground of the unconstitutionality of such statute,'" to cover suits to enjoin enforcement of state laws based on alleged conflict with a federal statute. *Id.* at 114 (quoting 28 U.S.C. §2281). The Court recognized that such suits do seek relief on "constitutional grounds," because "any determination that a state statute is void for obstructing a federal statute does rest on the Supremacy Clause of the Federal Constitution." *Id.* at 125. Nonetheless, while

(*continued* . . .)

California suggests that other provisions of the Constitution involve individual "rights," but this Court has decided on the merits many actions for prospective injunctive relief to enforce *structural* provisions of the Constitution. *See, e.g., Free Enterprise Fund*, 130 S.Ct. at 3151 n.2 (rejecting argument that "Appointments Clause or separation-of-powers claim should be treated differently than every other constitutional claim"); *Youngstown Sheet & Tube Co. v. Sawyer*, 343 U.S. 579, 583, 589 (1952) (steel mill seizures exceeded President's constitutional powers); *Hill v. Wallace*, 259 U.S. 44, 67-68, 70 (1922) (federal statutory provision unenforceable because exceeded Congress' enumerated powers); *cf. Dennis v. Higgins*, 498 U.S. 439, 458 (Kennedy, J., dissenting) (like Contracts Clause, even if Commerce Clause secures no "rights" in the §1983 sense, "courts provide a person injured by taxation that exceeds the limits of the Commerce Clause the 'right to have a judicial determination, declaring the nullity of the attempt to' levy a discriminatory tax") (quoting *Carter v. Greenhow*, 114 U.S. 317, 322 (1885)).

That being so, there is no reason to distinguish suits for injunctive relief under the Supremacy Clause. As this Court has explained, "[a]n individual has a direct interest in objecting to laws that upset the constitutional balance between the National Government and the States when the enforcement of those laws causes injury . . . ." *Bond v. United States*, 131 S.Ct. 2355, 2364 (2011). Individual equitable suits to enforce the Supremacy Clause effectuate "[t]he Framers['] conclu[sion] that allocation of powers between the National Government and the States

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(. . . *continued*)
acknowledging that its reading of the statute was not "compelled" by its text, the Court chose to narrowly construe the jurisdiction of three-judge courts because of the particular concerns of the legislators who enacted the jurisdictional statute and "important considerations of judicial administration." *Id.* at 126-29.

enhances freedom . . . [b]y denying any one government complete jurisdiction over all the concerns of public life." *Id.* at 2364. "In the tension between federal and state power lies the promise of liberty." *Gregory v. Ashcroft*, 501 U.S. 452, 459 (1991).

California does not show otherwise by pointing out that the framers intended the Supremacy Clause to be a "rule of decision" governing how to resolve conflicts between federal and state law when they arose. Pet. Br. 17-18, 35-36. Almost every provision of the Constitution acts as a "rule of decision" when cases implicating it arise. More to the point, the framers understood that a court with equity jurisdiction would have the power to decide suits seeking to "set aside" and "declare . . . void" unconstitutional state laws in order to ensure the supremacy of national law. 2 Max Farrand, *The Records of the Federal Convention of 1787*, at 27 (1911 ed.) (Madison); *id.* at 28 (Morris); *id.* at 391 (Wilson); *see supra* at 11-16.

II. STATE LAWS THAT CONFLICT WITH THE MEDICAID ACT ARE PREEMPTED UNDER THE SUPREMACY CLAUSE AND MAY BE ENJOINED BY THE FEDERAL COURTS

The above discussion about the equitable authority of the federal courts applies with equal force to all claims brought directly under the Supremacy Clause to enjoin state laws that are inconsistent with federal statutes. Yet California contends that federal statutes adopted under the Spending Clause are different. According to California, "the Supremacy Clause and preemption have no role in a dispute over a state's compliance with a funding condition set forth in a Spending Clause statute," such as the Medicaid Act. Pet. Br. 18, 46-49. These contentions are meritless.

1. California initially submits that the Supremacy Clause never comes into play when Congress legislates pursuant to its spending powers because "[t]he relationship between the federal and state governments in this context is defined *not* by the supremacy of federal law, but by the quasi-contractual agreement between the governments." Pet Br. 18 (emphasis in original), 46-47. But statutes adopted under the spending power carry the same force and authority as statutes enacted under other enumerated powers. This Court, therefore, has used the contract analogy only as an interpretive aid, while "be[ing] careful not to imply that all contract-law rules apply to Spending Clause legislation." *Barnes v. Gorman*, 536 U.S. 181, 186 (2002) (italics omitted); *see also Bennett v. Kentucky Dep't of Educ.*, 470 U.S. 656, 669 (1985) ("[T]he program cannot be viewed in the same manner as a bilateral contract governing a discrete transaction.").

For purposes of the Supremacy Clause, the Court has never distinguished between laws enacted pursuant to Congress' spending powers and other federal laws, and instead has in numerous decisions held state laws or regulations invalid under the Supremacy Clause because they are inconsistent "with a funding condition set forth in a Spending Clause statute." Pet. Br. 18.[10]

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[10] *See, e.g.*, *King v. Smith*, 392 U.S. 309, 333 n.34 (1968) ("There is of course no question that the Federal Government . . . may impose the terms and conditions upon which its money allotments to the States shall be disbursed, and that any state law or regulation inconsistent with such federal terms and conditions is to that extent invalid."); *Townsend v. Swank*, 404 U.S. 282, 285 (1971) ("We hold that the Illinois statute and regulation conflict with [the Social Security Act] and for that reason are invalid under the Supremacy Clause."); *id.* at 286 ("[A] state eligibility standard that excludes persons eligible for assistance . . . under federal AFDC standards violates the Social Security Act and is therefore invalid under the Supremacy Clause."); *California Dep't of Human Res. Dev. v. Java*, (*continued* . . .)

California ignores these precedents, asserting that the Supremacy Clause applies only to "Congress' exercise of power particularly with respect to commerce and treaties – areas in which Congress may exercise exclusive regulatory (i.e. preempting authority)" and that allowing California to defy federal Spending Clause statutes "does not frustrate the national purposes for which the Union was formed." Pet. App. 48-49 & n.18. To the contrary, the Supremacy Clause applies to *all* "Laws of the United States." U.S. Const., Art. VI, cl. 2. Among the "Laws of the United States" are those laws adopted by Congress pursuant to its powers to tax and spend to further the "general Welfare" (U.S. Const., Art. I, §8, cl. 1), which, contrary to California's assertion (Pet. Br. 49 n.18), are

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(. . . *continued*)
402 U.S. 121, 135 (1971) ("[E]nforcement of [the California statute] must be enjoined because it is inconsistent with . . . the Social Security Act."); *Carleson v. Remillard*, 406 U.S. 598, 601 (1972) ("If California's definition conflicts with the federal criterion [under the Social Security Act] then it . . . is invalid under the Supremacy Clause."); *Philpott v. Essex County Welfare Bd.*, 409 U.S. 413, 417 (1973) (state law preempted by Social Security Act "by reason of the Supremacy Clause"); *Shea v. Vialpando*, 416 U.S. 251, 266 (1974) (affirming injunction against Colorado welfare regulation that conflicts with Social Security Act); *Philbrook v. Glodgett*, 421 U.S. 707, 719 (1975) (same as to Vermont welfare regulation); *Youakim v. Miller*, 425 U.S. 231, 233 (1976) (per curiam) (remanding for determination of "Supremacy Clause claim" alleging Illinois' regulation was inconsistent with Social Security Act); *Miller v. Youakim*, 440 U.S. 125, 132 (1979) (state law "is inconsistent with the Social Security Act and therefore invalid under the Supremacy Clause"); *Blum v. Bacon*, 457 U.S. 132, 145-46 (1982) ("Because New York's no-cash and loss-or-theft rules conflict with a valid federal regulation [adopted under the Social Security Act], they are invalid under the Supremacy Clause."); *Bennett v. Arkansas*, 485 U.S. 395, 397 (1988) (inconsistency between state law and Social Security Act "amounts to a 'conflict' under the Supremacy Clause — a conflict that the State cannot win"); *Arkansas Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S. 268, 292 (2006) (state lien on tort settlements inconsistent with Medicaid Act and therefore invalid).

among the "enumerated powers under the Constitution," no less than the power to "regulate Commerce." U.S. Const., Art. I, §8, cl. 3; *see South Dakota v. Dole*, 483 U. S. 203, 206-207 (1987).

Ongoing state defiance of any valid federal law, moreover, does "frustrate the national purposes for which the Union was formed," regardless of which provision(s) of the Constitution authorized Congress to adopt that law. As the Court explained in *Green v. Mansour*, 474 U.S. 64 (1985) – a Spending Clause case – "the availability of prospective relief of the sort awarded in *Ex parte Young* gives life to the Supremacy Clause. Remedies designed to end a continuing violation of federal law are necessary to vindicate the federal interest in assuring the supremacy of that law." 474 U.S. at 68.

The Court also recognized in *Lawrence County*, 469 U.S. at 259 n.6, that a claim that a state law is preempted by a federal statute adopted under Congress' Spending Clause authority states a federal claim under the same rationale applied in *Shaw*. *Lawrence County* held that a state law regulating the distribution of funds that local government units receive from the federal government was preempted by the Payment in Lieu of Taxes Act, 31 U.S.C. §6901 *et seq.*, which granted localities the authority to make their own decisions about the use of federal funds. The Eighth Circuit had vacated a judgment for the plaintiff county in its federal court preemption injunction action based on the court's determination that the plaintiff did not "affirmatively assert[] a federal claim." *Lawrence County v. South Dakota*, 668 F.2d 27, 30-31 (8th Cir. 1982). Relying on *Shaw*, this Court recognized that "[t]his ruling was erroneous." *Lawrence County*, 469 U.S. at 259 n.6. The Supremacy Clause claim here is indistinguishable from the federal court claim in *Lawrence County*.

2. California next contends – again without acknowledging 40 years of contrary precedent (*see supra* n.10) – that "the Supremacy Clause cannot be used to 'invalidate' or declare 'null and void'" a state law preempted by the Medicaid Act, because state participation in the Medicaid program is *voluntary*. Pet. Br. 47-48. But it does not follow from California's freedom to refrain from participating in Medicaid that the courts cannot enjoin its officials from implementing a state law contrary to the Medicaid Act while the State does participate in that program.

For example, the Civil Rights Act of 1964 requires the owner of any "inn, hotel, motel or other establishment which provides lodging to transient guests" to offer lodging to all on non-discriminatory grounds. *Heart of Atlanta Motel, Inc. v. United States*, 379 U.S. 241, 247 (1964). It does not require anyone to open a hotel or forbid anyone from exiting the hotel business. Yet a prospective injunction would be an appropriate remedy to prevent the continuing violation of federal law by a defendant who is operating a hotel. *See id.* at 242, 244-45.

The Court recognized in *King v. Smith* – a Spending Clause case – that "States are not required to participate in the [federal] program" (392 U.S. at 316), but held an Alabama "regulation . . . invalid because it defines 'parent' in a manner that is inconsistent with . . . the Social Security Act." *Id.* at 333; *see also Guardians Ass'n v. Civil Serv. Comm'n of N.Y.C.*, 463 U.S. 582, 596 (1983) (plurality opinion) ("[A] court may identify the violation and enjoin its continuance . . . [;] the recipient has the option of withdrawing and hence terminating the prospective force of the injunction."); *Golden State Transit Corp. v. City of Los Angeles*, 493 U.S. 103, 112 (1989) (recognizing that the State in Spending Clause preemption cases could "relieve itself of federal obligations by declining federal funds").

3. This Court also long ago rejected California's argument (Pet. Br. 47-48) that Congress' authorization of a withholding-of-federal-funds administrative remedy as part of Spending Clause programs established by the Social Security Act (which include the Medicaid program) demonstrates that Congress intended to strip the courts of their "traditional jurisdiction" to enjoin enforcement of state laws that are invalid under the Supremacy Clause. *See Rosado v. Wyman*, 397 U.S. 397, 420 (1970) ("We adhere to *King v. Smith*, 392 U.S. 309 (1968), which implicitly rejected the argument that the statutory provisions for HEW review of plans should be read to curtail judicial relief.").

Even if Congress *could* have established the Medicaid program differently, it did not do so. This Court interpreted the pertinent statutes many decades ago and found "*not the slightest indication* that Congress meant to deprive federal courts of their traditional jurisdiction to hear and decide federal questions in this field." *Rosado*, 397 U.S. at 422 (emphasis added). The United States agrees. U.S. Br. 32 n.12 ("The United States is *not* suggesting that Congress has 'displayed an intent not to provide the more complete and more immediate relief that would otherwise be available under *Ex parte Young*.'") (quoting *Verizon Md., Inc. v. Public Serv. Comm'n of Md.*, 535 U.S. 635, 647 (2002)) (emphasis added; further internal quotations and citations omitted).

Congress' adoption of the so-called "*Suter*-fix" amendments to the Medicaid Act in 1994 ratified the interpretation of the statute that California now asks the Court to reject. The 1994 amendments were adopted after this Court's decision in *Suter v. Artist M.*, 503 U.S. 347 (1992), which held that a provision of the Medicaid Act did not secure individual "rights" within the meaning of §1983 because, among other things, the provision concerned the

contents of a state plan. Congress responded by amending the Medicaid Act to provide, in pertinent part, that "[i]n an action brought to enforce a provision of this chapter, such provision is not to be deemed unenforceable because of its inclusion in a section of this chapter requiring a State plan or specifying the required contents of a State plan." 42 U.S.C. §1320a-2; *see also id.* §1320a-10 (same language). This amendment cannot be reconciled with California's proposed interpretation of the Medicaid Act, under which the statutory requirements for a state plan are simply judicially unenforceable administrative provisions to guide continued funding decisions.

Congress also has amended the Medicaid Act many times after *Rosado* without changing the statutory structure to make the administrative remedy exclusive. *Cf. Herman & MacLean v. Huddleston*, 459 U.S. 375, 384-86 (1983) (in light of "well-established judicial interpretation" permitting suits under §10(b) of Securities Exchange Act of 1934 "regardless of the availability of express remedies," Congress' decision when amending the securities laws in 1975 "to leave Section 10(b) intact suggests that Congress ratified the cumulative nature of the Section 10(b) action").[11]

In light of the particular judicial history of the Social Security Act, even if the Court wished to give notice that it would henceforth view the existence of a withholding-of-funds remedy in new Spending Clause statutes as indicative of an intent to withdraw the traditional author-

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[11] Contrary to California's contention (Pet. Br. 31-33), Congress' 1997 amendment repealing the Medicaid Act provision at issue in *Wilder v. Virginia Hospital Association*, 496 U.S. 498 (1990) – the Boren amendment – has no bearing on this case. Congress' repeal of the Boren Amendment meant that participating states were no longer required to comply with that provision. Congress therefore did not address the availability of private litigation to enforce the Boren Amendment, much less as a general matter.

ity of the federal courts to entertain Supremacy Clause injunction actions, it would betray Congress' reliance on prior Court decisions to apply such a rule here. *Cf. Cannon v. University of Chicago*, 441 U.S. 677, 717-18 (1979) (Rehnquist, J., concurring) (explaining that while Congress was now on notice that Court would be reluctant in future to imply statutory causes of action, Court would not apply that rule retroactively because "we do not write on an entirely clean slate," and Congress had relied on prior interpretations of law).

4. Finally, there is no tension between the Court's reasoning in *Pennhurst State School & Hospital v. Halderman*, 451 U.S. 1 (1981), and injunctions under the Supremacy Clause to prohibit enforcement of state laws that are inconsistent with Spending Clause statutes.

Pennhurst held only that obligations imposed upon participating states by federal spending power programs must be imposed "unambiguously" so participating states are "voluntarily and knowingly" undertaking those obligations. *Id.* at 17. This "clear notice" rule governs whether an obligation exists at all. That is, absent "clear notice," a purported obligation in a Spending Clause statute would be neither enforceable administratively by the federal government nor through private lawsuits. *See South Dakota v. Dole*, 483 U.S. 203, 207-209 (1987) (discussing "clear notice" requirement as basic limitation on federal spending power and applying it to case involving federal withholding-of-funds remedy, not private enforcement).

When a participating state does have "clear notice" of an obligation imposed by federal law, however, a prospective injunction to preclude implementation of a state law that conflicts with the federal statute serves only to hold the state to the "deal" that the state "voluntarily and knowingly" accepts. *Cf. Winkleman v. Parma City Sch. Dist.*, 550 U.S. 516, 534 (2007) ("Our determination that

IDEA grants to parents independent, enforceable rights does not impose any substantive condition or obligation on States they would not otherwise be required by law to observe."); *Bell v. New Jersey*, 461 U.S. 773, 790 n.17 (1983) (Congress need not warn in advance of "the remedies available against a noncomplying California"). While California might prefer that enforcement be limited to the ineffectual threat of withholding of funds by an overburdened federal agency, it does not have a legitimate interest in continuing to implement a preempted law. Moreover, a court ruling that a state law is preempted allows the state the option to withdraw from the federal program if it wishes to avoid the prospective injunction, or to "voluntarily and knowingly" continue its participation. *See supra* at 24.

California seeks to smuggle into this case the issue whether its state statute was in fact in conflict with 42 U.S.C. §1396a(a)(30)(A) by suggesting that §30(A) is too "nebulous" to provide a judicially enforceable standard. But the lower courts disagreed with California, and this Court denied certiorari on the question whether §30(A) preempts the state statute. The Court must therefore take as a given in this case that §30(A) provides sufficiently clear notice to impose an obligation under *Pennhurst*, and that California officials sought to defy federal law by implementing a state statute that is void under the Supremacy Clause.

III. THE COURT'S JURISPRUDENCE REGARDING 42 U.S.C. §1983 CLAIMS AND STATUTORY RIGHTS OF ACTION DOES NOT APPLY TO PROHIBITORY INJUNCTIONS SOUGHT DIRECTLY UNDER THE CONSTITUTION

A. Section 1983 claims and preemption injunction actions to enforce the Supremacy Clause are substantively, historically, and practically distinct

This Court's jurisprudence regarding whether statutes create individual "rights" enforceable under §1983 is simply not relevant to suits for prospective injunctive relief directly under the Supremacy Clause. California acknowledges that this Court has approved of injunctive relief against implementation of state laws preempted by federal statutes without relying on "rights" enforceable under *Gonzaga University v. Doe*, 536 U.S. 273 (2002). Pet. Br. 43-44 & n.15. This Court has consistently recognized that the unavailability of a claim under §1983 does not exclude traditional injunctive relief to enforce the Constitution.[12] That is equally true of suits to enforce the Constitution's Supremacy Clause. *See Golden State*, 493 U.S. at 119 (Kennedy, J., dissenting) (even where §1983

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[12] *Compare Carter v. Greenhow*, 114 U.S. 317, 322-323 (1885) (holding that Contracts Clause did not "secure" rights enforceable through §1983, but noting that Congress "has legislated in aid of the rights secured by that clause of the constitution . . . by conferring jurisdiction upon the [lower federal] courts . . . of all cases arising under the constitution and laws of the United States"), *with White v. Greenhow*, 114 U.S. 307, 308 (1885) (permitting suit to enforce Contracts Clause to proceed under federal jurisdiction statute); *see also Holt v. Indiana Mfg. Co.*, 176 U.S. 68, 72 (1900) (suit could not be brought under §1983, but "[i]f state legislation impairs the obligations of a contract . . . remedies are found in [what is now 28 U.S.C. §1331], giving to the circuit courts jurisdiction of all cases arising under the Constitution and laws of the United States").

damages claims are unavailable, plaintiffs "may vindicate . . . pre-emption claims by seeking declaratory and equitable relief in the federal district courts through their powers under federal jurisdictional statutes").

Equitable suits to enjoin allegedly unconstitutional state laws, including suits to enforce the Supremacy Clause, were available long before Congress adopted what is now §1983. *See supra* at 7-8, 16. By enacting the provision that became §1983, Congress provided private litigants previously unavailable remedies, broadened the range of conduct by public officials that could be challenged by injured individuals as violating their federal rights, and expanded the jurisdiction of the federal courts. This Court's recognition of limits on this statutory expansion in *Gonzaga* and its progeny, based on the particular statutory text and purpose of §1983, does not affect the pre-existing authority of the federal courts to hear claims for injunctive relief directly under the Supremacy Clause.[13]

1. Section 1983 expanded the remedies available to private litigants. The sole remedies available for equitable claims under the Supremacy Clause are injunctive and declaratory relief against the operation of the preempted state law. By contrast, §1983 provides for damages, including punitive damages. *See Carlson v. Green*, 446 U.S. 14, 22 (1980).

When it was first adopted in 1871, supporters of the provision that became §1983 confirmed their intent to provide for monetary relief. *See, e.g.*, Cong. Globe, 42d

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[13] California's reliance on *Astra USA, Inc. v. Santa Clara County*, 131 S.Ct. 1342, 1345 (2011) (Pet. Br. 34), is misplaced. *Astra* did not involve either the Supremacy Clause or §1983, and, as discussed in the text, Supremacy Clause injunction actions predate and are distinct from §1983 claims.

Cong., 1st Sess. App. 477 (1871) (statement of Rep. Dawes) (provision meant to protect "every American citizen in the full, free, and undisturbed enjoyment of every right, privilege, or immunity secured to him by the Constitution" by "giving him a civil remedy in the United States courts for any damage sustained in that regard"); *id.* at App. 446 (statement of Rep. Butler) (pointing to the kinds of rights violations the provision was meant to address by insisting that "[n]o other nation on earth would permit its citizens to be thus tortured and murdered and its officers stricken down defenseless and unavenged," but would demand "reparation" and ensure that "full indemnity is made" by those responsible).

Opponents similarly complained that the provision that became §1983 "'gives to any person who may have been injured in any of his rights, privileges, or immunities of person or property, a *civil action for damages* against the wrongdoer in the Federal courts,'" and lamented the "'mercenary considerations'" this expansion of remedies was likely to foster. *Monroe v. Pape*, 365 U.S.167, 178 (1961) (quoting Cong. Globe, 42d Cong., 1st Sess. App. 50 (1871) (statement of Rep. Kerr)) (emphasis added); *see also* Cong. Globe, 42d Cong., 1st Sess. App. 365-66 (1871) (statement of Rep. Arthur) (decrying possibility that state officials would be subjected to "heavy damages and amercements"); *id.* at App. 385 (statement of Rep. Lewis) (objecting that provision makes state judges "liable to a suit in the Federal court and *subject to damages*" and "a ministerial officer is subject to the same pains and penalties") (emphasis added).

This Court's §1983 jurisprudence has largely been an explication of the various contexts in which damages and other enhanced remedies (which now include attorney's fees, *see* 42 U.S.C. §1988(b)) are available. *See, e.g.*, *Gonzaga*, 536 U.S. at 276 ("The question presented is

whether a student may sue a private university for [compensatory and punitive] damages" under §1983, to enforce provisions of particular federal statute). In contrast, the issue before this Court now concerns the availability of traditional equitable relief."

2. Section 1983 also provides a cause of action to challenge state violations of federal rights that could not be challenged in a traditional suit to enforce the Supremacy Clause.

The Supremacy Clause provides that federal law is supreme over "any Thing in the Constitution or Laws of any State." U.S. Const., Art. VI, cl. 2. It thus preempts – *i.e.*, nullifies or voids – state and local laws and regulations that conflict with or frustrate the objectives of federal law. *See Chicago & N.W. Transp. Co. v. Kalo Brick & Tile Co.*, 450 U.S. 311, 317 (1981) ("The underlying rationale of the pre-emption doctrine, as stated more than a century and a half ago, is that the Supremacy Clause invalidates state laws that 'interfere with or are contrary to, the laws of congress . . . .'") (quoting *Gibbons v.*

" Amicus National Governors Association points out that some members of the Congress that enacted in 1871 the legislation now codified as §1983 believed it provided "new" equitable remedies in federal court. Nat'l Govs. Ass'n Br. 29 (italics omitted). Section 1983 did provide for *some* equitable remedies not previously available in federal court, both by expanding the kinds of state action that could be challenged by private litigants, *see infra* at 33, and by providing that suits pursuant to its provisions were "to be prosecuted in the several district or circuit courts of the United States" (Ku Klux Act of April 20, 1871, ch. 22, §1, 17 Stat. 13), thus greatly expanding the federal courts' jurisdiction, which had previously generally been limited to cases in diversity, *see supra* n.2. The Congress that enacted what is now §1983 also fully understood that preemption injunction actions to enforce the Constitution were previously available where the courts had jurisdiction. *See, e.g.*, Cong. Globe, 42d Cong., 1st Sess. App. 420 (1871) (statement of Rep. Bright); *Osborn*, 22 U.S. 738.

Ogden, 22 U.S. (9 Wheat.) 1, 211 (1824)); *McCulloch v. Maryland*, 17 U.S. (4 Wheat.) 316, 436 (1819) (preempted state law is "unconstitutional and void"). A cause of action to enforce the Supremacy Clause is thus only available to challenge state or local statutes, regulations, ordinances, or policies with the force of *law*.

By contrast, §1983 authorizes challenges not only to state laws, but also to deprivations of rights, privileges, or immunities by individual actions or failures to act by state officials "under color of" law, even when those actions or failures to act *violate* state or local law. *Monroe*, 365 U.S. at 172 (§1983 provides remedy for rights violations caused "by an official's abuse of his position," even if official violated state law). Section 1983 thus provides a mechanism for challenging a broad range of state and local action or inaction that does not have the force of law. *See, e.g., id.* (warrantless search and arrest); *Wilson v. Garcia*, 471 U.S. 261 (1985) (police beating). The Supremacy Clause does not reach so far – which was among the reasons why Congress felt the need to enact §1983. *See Monroe*, 365 U.S. at 172-83 (discussing legislative history).[15]

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[15] The United States points to *Blessing v. Freestone*, 520 U.S. 329 (1997), and *Suter v. Artist M.*, 503 U.S. 347 (1992), as cases "in considerable tension" with the availability of preemption injunction actions to enforce the Supremacy Clause. U.S. Br. 26-27. But those cases involved challenges to state executive branch *actions or failures to act*, not, as here, preemption challenges to the enforcement of state *laws or regulations*. *See Blessing*, 520 U.S. at 337, 345-46; *Suter*, 503 U.S. at 352. The parties in *Blessing* and *Suter* did not brief the possibility that plaintiffs' challenges could proceed under the Supremacy Clause, and thus the Court did not need to reach the question whether the actions challenged in those cases or any other state executive actions may amount to state "laws" subject to challenge under the Supremacy Clause. *Cf.* David Sloss, *Constitutional Remedies for Statutory Violations*, 89 Iowa L. Rev. 355, 365-69, 375 (2004) (discussing Court's disparate approaches to challenges to state legislative and executive actions alleged to conflict with federal law).

3. The limitations this Court has applied to §1983 claims stem from the specific language of §1983, which applies to deprivations of "*rights, privileges, or immunities* secured by the Constitution and laws" of the United States. (Emphasis added.) *See Golden State*, 493 U.S. at 106 ("Section 1983 speaks in terms of 'rights, privileges, or immunities,' not violations of federal law.").

By contrast, the Supremacy Clause makes no reference to "rights." Rather, it declares that the "Constitution, and the Laws of the United States . . . shall be the supreme Law of the Land . . . any Thing in the Constitution or Laws of any State to the Contrary notwithstanding." U.S. Const., Art. VI, cl. 2. While the *Gonzaga* Court's focus on rights-creating statutory language in the context of §1983 follows from the text of §1983 itself, a similar analysis does not follow from the language of the Supremacy Clause, which focuses on the relationship between state and federal laws. *See Golden State*, 493 U.S. at 117 (Kennedy, J., dissenting) (in contrast to §1983, "[p]re-emption concerns the federal structure of the Nation rather than the securing of rights, privileges, and immunities to individuals").[16]

B. Implied statutory rights of action are distinct from injunction actions to enforce the Supremacy Clause

This Court's implied statutory right of action jurisprudence is similarly inapplicable to suits to enforce the

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[16] The United States places undue reliance on *Maine v. Thiboutot*, 448 U.S. 1 (1980). U.S. Br. 28-29. The Court in *Thiboutot* stated only that, in previous cases involving the Social Security Act (SSA), §1983 was "the exclusive *statutory* cause of action because . . . the SSA affords no private right of action against a State." 448 US. at 6 (emphasis added). The parties in *Thiboutot* did not brief the availability of a direct cause of action under the Supremacy Clause for injunctive relief. The *Thiboutot* Court also included, in a compilation of prior decisions, some cases that under *Gonzaga* could not be brought under §1983.

Constitution, including injunctive suits to enforce the Supremacy Clause.

Statutory rights of action, like §1983 claims and unlike Supremacy Clause injunction actions, permit both damages suits and challenges to actions or inactions that do not have the force of law. *See Franklin v. Gwinnett County Pub. Schs.*, 503 U.S. 60, 63-64, 65-66 (1992) (damages suit alleging sexual harassment, explaining that, where Court finds implied statutory right of action, it "presume[s] the availability of all appropriate remedies [including damages] unless Congress has expressly indicated otherwise").

And implied statutory actions go even further than §1983 claims, permitting suits against private defendants for entirely private action. *Cf. Building. & Constr. Trades Council of Metro. Dist. v. Associated Builders & Contractors of Mass./R.I., Inc.*, 507 U.S. 218, 229 (1993) ("[T]he Supremacy Clause does not require pre-emption of private conduct."). The Court's implied statutory right of action jurisprudence has developed primarily in the context of suits against private parties for damages – a broad category of cases all sharing no tie to the Supremacy Clause. *See, e.g., Cort v. Ash*, 422 U.S. 66, 68 (1975) (shareholder derivative suit for damages against corporate directors).[17] This line of authority does not gov-

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[17] *See also Morrison v. National Australia Bank Ltd.*, 130 S.Ct. 2869, 2875-76 & n.1, 2881 n.5 (2010) (foreign investors' securities fraud damages suit against foreign banking corporation); *Stoneridge Inv. Partners, LLC v. Scientific-Atlanta*, 552 U.S. 148, 152-53, 164-65 (2008) (investors' securities fraud damages suit against corporation); *Central Bank of Denver, N.A. v. First Interstate Bank of Denver, N.A.*, 511 U.S. 164, 167-68 (1994) (bondholder's securities fraud damages suit against indenture trustee); *Musick, Peeler & Garrett v. Employers Ins. of Wausau*, 508 U.S. 286, 288 (1993) (action for con-

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ern this case, which just involves traditional equitable relief against government officials directly under the Constitution.

Even in cases involving public defendants, the statutes at issue in this Court's implied statutory right of action holdings applied to private actors as well, so the Court's conclusion also decided whether the statute created an implied right of action against private defendants. For example, in

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tribution by stock issuers against attorneys and accountants); *Virginia Bankshares, Inc. v. Sandberg*, 501 U.S. 1083, 1086-88 (1991) (minority shareholders' damages action against corporation and directors); *Karahalios v. National Fed'n of Fed. Employees, Local 1263*, 489 U.S. 527, 529, 532-33 (1989) (damages suit against union); *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 136, 145-48 (1985) (beneficiary's damages suit against employee benefit plan fiduciary); *Daily Income Fund, Inc. v. Fox*, 464 U.S. 523, 525-26, 534-36 (1984) (shareholder derivative damages suit against investment company); *Herman & MacLean v. Huddleston*, 459 U.S. 375, 377-80 (1983) (securities fraud damages suit against accounting firm); *Texas Industries, Inc. v. Radcliff Materials, Inc.*, 451 U.S. 630, 632-33, 639-40 (1981) (suit for contribution against concrete firms); *Northwest Airlines, Inc. v. Transport Workers Union of Am., AFL-CIO*, 451 U.S. 77, 82, 91-95 (1981) (employer's suit for contribution against union); *Universities Research Ass'n, Inc. v. Coutu*, 450 U.S. 754, 762-64, 770-73 (1981) (employee's damages suit against university consortium); *Transamerica Mortg. Advisors, Inc. (TAMA) v. Lewis*, 444 U.S. 11, 13-16, 19-24 (1979) (shareholder derivative damages suit against investment adviser); *Touche Ross & Co. v. Redington*, 442 U.S. 560, 562, 568-71 (1979) (damages suit against accounting firm); *Cannon v. University of Chicago*, 441 U.S. 677, 680 n.1, 688-709 (1979) (damages suit against private universities); *Santa Fe Indus., Inc. v. Green*, 430 U.S. 462, 466-68, 477-80 (1977) (minority shareholders' securities fraud damages suit); *Piper v. Chris-Craft Indus., Inc.*, 430 U.S. 1, 4, 9-10, 21, 24, 37-41 (1977) (damages action against competitor in corporate takeover contest); *cf. Astra*, 131 S.Ct. at 1345, 1347 (third-party-beneficiary damages suit against pharmaceutical companies alleging contract breach substantively identical to suit pursuant to implied statutory right of action).

Alexander v. Sandoval, 532 U.S. 275 (2001), although the defendant was a state official, the federal regulations that the plaintiffs alleged the official had violated were authorized by a federal statute (Title VI) that also covered conduct by private parties. *See also Middlesex County Sewerage Auth. v. National Sea Clammers Ass'n*, 453 U.S. 1 (1981) (environmental statutes that reached private conduct); *California v. Sierra Club*, 451 U.S. 287 (1981) (same).[18] Had the Court concluded that the statutes or regulations in these cases provided for an implied right of action, the holding would have permitted suits against private defendants. In contrast, Supremacy Clause actions by definition are only available to prevent public officials from implementing preempted state laws.

The Court's modern approach to implied statutory rights of action stems from a concern that permitting suits in federal court where Congress has not authorized them "runs contrary to the established principle that [t]he jurisdiction of the federal courts is carefully guarded against expansion by judicial interpretation . . . and conflicts with the authority of Congress under Art. III to set the limits of federal jurisdiction." *Stoneridge Inv. Partners, LLC v. Scientific-Atlanta*, 552 U.S. 148, 164-65 (2008) (quoting *Cannon*, 441 U.S. at 746-47 (Powell, J., dissenting)) (internal quotation marks and citations omitted). The long-established availability of preemption injunction suits to enforce the Supremacy Clause is fully consistent with these principles. Congress authorized the federal courts to exercise their traditional equitable authority, so long as the dispute otherwise fell within the limits of the court's jurisdiction. *Supra* at 15-17.

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[18] *Sandoval*, *Sea Clammers*, and *Sierra Club* all also involved challenges to state executive branch actions, not legislatively enacted laws. *See supra* n.15.

IV. CALIFORNIA'S PROPOSED LIMITATION ON SUPREMACY CLAUSE ACTIONS FOR PROHIBITORY INJUNCTIONS IS NOT SUPPORTED BY HISTORY, LOGIC, OR PRECEDENT

California urges that, if the Court recognizes any federal court authority to issue equitable relief directly under the Supremacy Clause, it should limit that authority to cases in which preemption is asserted as a sort of anticipatory defense, to forestall enforcement of state or local regulation. Pet. Br. 42-44. The case law does not support this limitation, and imposing it for the first time now would undermine the purpose of the Supremacy Clause.

As an initial matter, California is wrong that *Shaw* and other preemption cases that arose directly under the Supremacy Clause would still be viable §1983 cases were this Court to eliminate the Supremacy Clause injunction cause of action, because they involve individual "rights." Pet. Br. 42-43 & n.12. These cases involve statutes that do not contain the "rights-creating language" that this Court has deemed "critical." *Gonzaga*, 536 U.S. at 283-84 & n.3, 287.

ERISA's preemption provision, for example, simply states that ERISA "shall supersede any and all State laws insofar as they . . . relate to any employee benefit plan" (29 U.S.C. §1144(a)), and does not contain statutory language that would support recognition of any "right" under §1983.

Likewise, the National Labor Relations Act ("NLRA") does not contain any "rights-creating" language that would apply to employers. In contending otherwise, California relies on authority that predates *Gonzaga*, and thus reached a different result than would be required under current authority. *See Golden State*, 493 U.S. at 451 (acknowledging absence of statutory text securing "rights" under NLRA, but holding right to be free from regulation to be "implicit"). Moreover, even if it could

somehow be said that the NLRA, *sub silentio*, grants businesses a *Gonzaga*-type "right" to be free from regulation, it is implausible that the NLRA could be read also to grant a "right" to wrong-doers to avoid "supplemental sanction" for conduct concededly subject to federal prohibition and penalty, which was the issue in *Wisconsin Department of Industry, Labor & Human Relations v. Gould Inc.*, 475 U.S. 282, 283-84, 287-88 (1986) (state statute prohibiting state purchases of products from repeat NLRA violators preempted in injunctive suit brought by employer because statute imposed supplemental sanction on conduct regulated exclusively by federal government).

This would be equally true of the many federal statutes that, like the NLRA, contain *no* preemption language at all, much less rights-creating language, but have been held in preemption injunction suits to preempt state regulation. *See, e.g., City of Burbank v. Lockheed Air Terminal, Inc.*, 411 U.S. 624, 633 (1973) (Federal Aviation Act and Noise Control Act preempted city ordinance regulating aircraft noise based on "pervasive nature of the scheme of federal regulation of aircraft noise," despite absence of express preemption provision); *Hines v. Davidowitz*, 312 U.S. 52, 68-74 (1941) (state alien registration law preempted by Federal Alien Registration Act).

Having established that preemption cases could not simply be brought under §1983, we turn to California's "anticipatory defense" theory.

A. The Court's preemption cases cannot be explained as all involving anticipatory defenses to state regulation or quasi-regulation

1. California's theory is that, even if no statutory "cause of action" is necessary to obtain injunctive relief under the Supremacy Clause, this Court has entertained preemption claims absent such a statutory cause of action only when

asserted in anticipation of state proceedings to enforce regulation of a plaintiff's conduct. Pet. Br. 43-44; *see also* U.S. Br. 19, 21-22; Nat'l Govs. Ass'n Br. 23-26. Initially, regardless of the truth of this proposition as a descriptive matter, no party or amicus offers a reasoned justification for limiting the force of the Supremacy Clause to this context.

Historical practice at the time the Supremacy Clause was adopted lends no support, for while traditional equity suits did include those to enjoin actions at law (as amici correctly point out, Nat'l Govs. Ass'n Br. 23-25), they were not limited to such cases.[19] Early authorities on injunctive relief noted that "[i]t would indeed be difficult to enumerate" all the categories of cases in which injunctions were available,

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[19] As previously discussed (*supra* at 12-15), suits seeking injunctive relief were generally available to prevent unlawful injury where there was no adequate remedy at law, including to redress or prevent injury from statutory violations. *E.g.*, *Bosanquett v. Dashwood, Forrester*, 39-40 (Ch. 1734) (suit in equity for refund based on usury statute where no action at law was available; "tho' a court of equity will not differ from the courts of law in the exposition of statutes; yet does it often vary in the remedies given, and in the manner of applying them"); *see also* 1 John Fonblanque, *A Treatise of Equity*, ch. 1, §3, pp. 13-15 (1793) ("Every matter . . . that happens inconsistent with the design of the legislator . . . may find relief" in equity); 1 Story § 10. Injunctive relief was also available, for example, (a) to enforce trust obligations, *e.g.*, *Attorney General v. Heelis*, 2 Simons & Stuart 67 (Ch. 1824) (commissioners appointed under act of Parliament to provide local public services held to be equivalent of trustees subject to injunction to administer funds as required by statute); *see generally* 1 Pomeroy §§151-55; (b) to prevent waste, *e.g.*, *Portues v. Tapham*, Case No. 30, *Registrar's Book of Governor Keith's Court of Chancery* (Pa. 1735); *Wightman v. Brown*, 1 S.C. Eq. Rep. 166 (1790); *Attorney General v. Mayor &c. of Dublin*, 1 Bligh 312, 324, 339 (H.L. 1827) (where water users brought suit to restrain levies by corporation of Dublin allegedly "not warranted" by statute permitting rebuilding and maintenance of water pipes, Lord Redesdale (previously John Mitford) held suit in equity proper because it "was necessary to enforce the proper application of the funds [as required by statute], and was in the nature of an injunction to

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given "the endless variety of cases in which a plaintiff is entitled to equitable relief." Robert Henley Eden, *A Treatise on the Law of Injunctions* 2 (1821); *see also* 1 John Fonblanque, *A Treatise of Equity*, ch. 1, §3, p. 20 (1793) (with respect to jurisdiction of courts of equity, "in those cases where the principles of substantial justice entitle the party to relief, but the positive law is silent, it seems impossible to define with exactness its boundaries, or to enumerate with precision its various principles"). Consistent with these principles, suits to enjoin injurious actions taken by public officials were traditionally available in equity where the plaintiff was not threatened with any enforcement action at law. [20]

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stay waste"); *see also* Mitford at 123-24; (c) to maintain the status quo pending trial, *e.g.*, *Gray v. Yeamans*, *Journal of the Grand Council of South Carolina, 1671-1680* (S.C. 1671) (reprinted in *Records of the Court of Chancery of South Carolina, 1671-1779*, at 57-58 (1950 ed.)); *Burnet v. Corporation of Cincinnati*, 3 Ohio 73, 73 (1827); *see* Mitford at 122-23; (d) to restrain nuisances, *e.g.*, *Hall v. Mason*, Callis, 262 (1621); *Attorney-General v. Forbes*, 2 Mylne & Craig 123, 129-30 (Ch. 1836) (in suit against county magistrates, Chancellor held that "individuals, who conceive themselves aggrieved, may come forward and ask the assistance of the [High] Court [of Chancery], to prevent a public nuisance, from which they have individually sustained damage"); and (e) to avoid a multiplicity of suits, *e.g.*, *How v. Tenants of Bromgrove*, 1 Vernon 22 (Ch. 1681); *Ewelme Hospital v. Andover*, 1 Vernon 266, 267 (Ch. 1684); Mitford at 127-28; *see generally* 1 Pomeroy §§243-75. This list is far from exhaustive.

[20] *See, e.g.*, *Hughes v. Trustees of Morden College*, 1 Vesey 188 (Ch. 1748) (injunction to prevent turnpike commissioners from digging on land leased by plaintiff); *Gardner v. Trustees of Village of Newbury*, 2 Johns. Ch. Rep. 162 (N.Y. Ch. 1816) (injunction against village trustees' diversion of stream running through plaintiff's land); *Rankin v. Huskisson*, 4 Simons 13 (Ch. 1830) (injunction prohibiting construction of buildings by Commissioners of Woods and Forests); *Belknap v.*
(*continued . . .*)

Moreover, the proposed limitation also is not accurate as a descriptive matter. This Court has routinely authorized Supremacy Clause preemption injunctions when the plaintiffs faced no possible threat of enforcement or regulatory proceedings. In *Foster v. Love*, 522 U.S. 67, 68-69, 74 (1997), for example, this Court held a state open primary law that would have permitted election of congressional representatives in October to be preempted by the federal statute establishing a uniform date for federal elections. *See also Crosby v. National Foreign Trade Council*, 530 U.S. 363, 366 (2000) (state law restricting state purchases from companies doing business with Burma preempted because threatens to frustrate federal statutory objectives); *Dalton v. Little Rock Family Planning Servs.*, 516 U.S. 474, 476-78 (1996) (state law prohibiting use of funds for abortions challenged as preempted by Hyde Amendment); *Gould*, 475 U.S. at 283-84 & nn.1-2 (state statute prohibiting state purchases of products from repeat NLRA violators preempted); *Perez v. Campbell*, 402 U.S. 637, 641-43, 656 (1971) (Bankruptcy Act preempts state law automatically suspending driver's license for failure to satisfy judgment arising out of car accident that has been discharged in bankruptcy); *California Dep't of Human Res. Dev. v. Java*, 402 U.S. 121, 122-23, 135 (1971) (state law regarding timing of unemployment insurance suspension inconsistent with

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Belknap, 2 Johns. Ch. Rep. 463 (N.Y. Ch. 1817) (injunction to prevent canal commissioners from digging ditch that would drain pond and diminish water flow to plaintiff's mill); *Bromley v. Smith*, 1 Simons 8 (Ch. 1826) (injunction suit to prevent local treasurers from misapplying funds in manner inconsistent with act of Parliament); *Cooper v. Alden*, Harrington's Ch. Rep., 72 (Mich. Ch. 1838) (injunction prohibiting local officials from erecting buildings on public streets); *cf. Frewin v. Lewis*, 4 Mylne & Craig 249 (Ch. 1838) (reaching merits in suit to enjoin poor law commissioners from altering workhouse without local officials' consent); *see also supra* at 12-13.

Social Security Act plan provision); *Rosado v. Wyman*, 397 U.S. 397, 407, 415-16 (1970) (state law altering eligibility rules for welfare recipients inconsistent with Social Security Act Amendments of 1967).[21]

2. While California ignores the existence of cases where no enforcement proceedings could occur, the United States, recognizing that California's Supremacy Clause theory does not explain them, argues that cases such as *Crosby* and *Pharmaceutical Research & Manufacturers of America v. Walsh*, 538 U.S. 644, 649-50 (2003) ("*PhRMA*"), fall within another special, heretofore unrecognized, category where direct Supremacy Clause suits are authorized, because they involve, "in effect, [plaintiffs] asserting an immunity" from what were, "in essence, state regulatory requirements" directed at their "primary conduct." U.S. Br. 22-24 & nn.8-9. But even this creative addition to California's theory fails to explain numerous other cases in which this Court has entertained preemption claims involving disputes over government benefits, in which no such quasi-regulation argument could be made.

In *New York Telephone Co. v. New York State Department of Labor*, 440 U.S. 519 (1979), for example, the Court commented that, "[u]nlike . . . the main body of

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[21] Additional cases entertaining such Supremacy Clause preemption injunction actions on the merits include, *e.g.*, *Engine Mfrs. Ass'n v. South Coast Air Quality Mgmt. Dist.*, 541 U.S. 246, 248-51, 258-59 (2004); *Pharmaceutical Research & Mfrs. of Am. v. Walsh*, 538 U.S. 644, 649-50 (2003) ("*PhRMA*"); *California Div. of Labor Standards Enforcement v. Dillingham Constr.*, 519 U.S. 316, 319, 331-34 (1997); *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 649-50, 668 (1995); *Building & Constr. Trades Council of Metro. Dist. v. Associated Builders & Contractors of Mass./R.I., Inc.*, 507 U.S. 218, 222, 232-33 (1993); *New York Tel. Co. v. New York State Dep't of Labor*, 440 U.S. 519, 525, 545-46 (1979).

labor pre-emption cases, the case before us today does not involve any attempt by the State to regulate or prohibit private conduct in the labor-management field. It involves a state program for the distribution of benefits to certain members of the public." *Id.* at 532. Nonetheless, the Court entertained (and rejected on the merits) the employer's contention that the payment of benefits to striking employees was preempted by the NLRA and Social Security Act. *Id.* at 525, 529, 545-46; *see also Dalton*, 516 U.S. at 477-78 (Medicaid providers challenged state constitutional provision prohibiting use of funds for abortions in circumstances where Medicaid funding was authorized by Hyde Amendment); *Java*, 402 U.S. at 122-23, 135 (claimants challenged state law regarding timing of unemployment insurance suspension); *Rosado*, 397 U.S. at 407, 415-16 (welfare recipients challenged state law altering method of computing benefits).

The United States' novel attempt to carve out the cases presently before the Court also ignores this Court's decisions involving Supremacy Clause preemption challenges to state laws governing elections and other government practices that do not seek to regulate private conduct. In *Foster v. Love*, for example, the Court unanimously held that a Louisiana open primary law that permitted federal candidates to win election in October was preempted by the federal act establishing a uniform date for federal elections, in a challenge brought by Louisiana voters. 522 U.S. at 68-69, 74. And as previously discussed (*supra* at 9, 23), this Court stated in *Lawrence County* that a pre-emption challenge to a state law governing local governments' distribution of federal funds was cognizable in federal court. 469 U.S. at 259 n.6.

The United States also offers no legal or historical justification for its proposed distinction. No language in *Crosby*, *PhRMA*, or other relevant decisions explains that

preemption injunction actions under the Supremacy Clause are available only where the state action at issue "in essence" regulates private conduct. Rather, the decisions focus on the injury to or interference with federal interests that results from operation of the preempted state law. In *Crosby*, for example, this Court explained, "We will find preemption where . . . under the circumstances of a particular case, the challenged state law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." 530 U.S. at 372-73 (internal brackets and quotations omitted). The Court held the law invalid because, by imposing different economic pressure on Burma from that adopted by Congress, it undermined presidential authority and presented an obstacle to congressional purposes. *Id.* at 368, 373-74, 376, 378-82, 385.

Similarly, in *PhRMA*, the seven Justices who reached the merits of the preemption claim did not focus on whether an objective of the challenged program was to affect drug companies' conduct outside the Medicaid program. Rather, they disputed whether the curtailment of benefits through the preauthorization requirement would serve Medicaid-related goals, with the plurality concluding that it did and the concurrence/dissent reasoning that it would undermine congressional purposes to "burden Medicaid beneficiaries without serving a Medicaid goal." *Compare PhRMA*, 538 U.S. at 662-66 (plurality opinion), *with id.* at 684-87 (O'Connor, J., concurring in part and dissenting in part) (program preempted because not tailored to further Medicaid-related purpose and poses obstacle to purposes of Medicaid Act). *PhRMA*, *Crosby*, and similar cases are not distinguishable from this case in any relevant respect. At bottom, these cases all involve Supremacy Clause claims to enjoin allegedly preempted state laws affecting access to government benefits.

B. Recognition of California's proposed new limitation on preemption actions would undermine the purposes of the Supremacy Clause

The United States recognizes that preemption injunction actions "serve[] an important purpose in vindicating the supremacy of federal law." U.S. Br. 21 n.7. That purpose is implicated here, and would be ill-served by a rule that permitted States to defy federal law in ways that injure private persons while leaving those persons no legal recourse for asserting the supremacy of federal law.

If anything, the availability of private litigation to vindicate the supremacy of federal law is *more* important when no enforcement action could be brought. That is because a plaintiff who can raise a preemption defense will at least at some point be able to assert the supremacy of federal law and have the preemption issue adjudicated. A plaintiff who will face no enforcement action, by contrast, will simply lose benefits, be forced to vote in an unlawful election, or otherwise be injured by implementation of a preempted (and therefore void) state law. *See, e.g.*, *Foster*, 522 U.S. at 68-69, 74 (voters faced with unlawful early federal election); *Golden State*, 493 U.S. at 111-12 (employer faced with nonrenewal of taxi cab franchise in a case that could not, post-*Gonzaga*, be filed under §1983); *Gould*, 475 U.S. at 283-84 & nn.1-2 (employer faced with denial of state government contracts). "Remedies designed to end a continuing violation of federal law are necessary to vindicate the federal interest in assuring the supremacy of that law." *Green v. Mansour*, 474 U.S. 64, 68 (1985). Absent prohibitory injunctive relief, a state can continue to implement a state law that conflicts with federal law, the Supremacy Clause notwithstanding.

V. CALIFORNIA WAIVED ITS PRUDENTIAL STANDING ARGUMENT, WHICH IS ALSO MERITLESS

California's tacked-on prudential standing challenge should be rejected. The *Dominguez* plaintiffs' Article III standing is not disputed; nor could it be. Absent an injunction, the challenged state statute would have caused the beneficiary plaintiffs to lose health care services and reduced payments to the provider members of the plaintiff associations. Pet. App. (No. 09-1158) 81-82, 172-74.[22] Prudential standing is not jurisdictional, and California does not claim to have challenged at any stage below the *Dominguez* plaintiffs' prudential standing. Pet. Br. 50 & n.19. Nor did California raise prudential standing in its certiorari petition. Under such circumstances, this Court should not reach the issue. *See Taylor v. Freeland & Kronz*, 503 U.S. 638, 645-46 (1992).[23]

In any event, a prudential standing challenge would be meritless. Respondents do not seek to assert the "rights" of the federal government; rather, Respondents raise a preemption injunction cause of action under the Supremacy Clause based on the injury that California's

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[22] Amicus APA Watch confuses the constitutional and prudential standing inquiries. Moreover, Respondents do not rely on a third-party beneficiary theory of relief here, or sue under a statutory scheme requiring exhaustion of administrative processes, so amicus' arguments are not on point.

[23] Even if prudential standing concerns had been properly raised, when (as here) the court below has ruled on the merits issues and the "applicable constitutional questions have been and continue to be presented vigorously and 'cogently,'" disposition of the case on prudential standing grounds "can serve no functional purpose." *Craig v. Boren*, 429 U.S. 190, 193-94 (1976); *see also Singleton v. Wulff*, 428 U.S. 106, 114 (1976).

preempted enactments would otherwise inflict on them.[24] As this Court has explained, "[a]n individual has a direct interest in objecting to laws that upset the constitutional balance between the National Government and the States" when those laws cause injury, and prudential standing does not prevent suits by individuals who are injured by "governmental action taken in excess of the authority that federalism defines." *Bond*, 131 S.Ct. at 2363-65 (analogizing also to separation-of-powers cases). Such claims "need not depend on the vicarious assertion of a State's [or, in this case, federal government's] constitutional interests . . . ." *Id.* at 2365.[25] California's argument to the contrary would foreclose prudential standing in any case in which plaintiffs assert that a federal statute that lacks rights-creating language nonetheless has preemptive force, thwarting vindication of important Supremacy Clause interests and exposing citizens to continuing harm from illegal government action.[26]

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[24] California apparently confuses the third-party prudential standing limitation doctrine as requiring plaintiffs to demonstrate a legal "right" within the meaning of §1983 or implied-statutory-right-of-action jurisprudence. Pet. Br. 51. But this Court has recently clarified that "the question whether a plaintiff states a claim for relief goes to the merits in the typical case, not the justiciability of a dispute, and conflation of the two concepts can cause confusion." *Bond*, 131 S.Ct. at, 2362 (internal quotation marks and citations omitted). Respondents claim an injunctive right of action under the Supremacy Clause, and assert claims based on injury to their own interests; any question as to their right to enforce the Supremacy Clause relates to the merits of this case, not prudential standing.

[25] *Bond* also rejects California's argument that plaintiffs who have suffered concrete injury from an unconstitutional statute assert a generalized grievance when challenging that statute. *See* 131 S.Ct. at 2366-67.

[26] Plaintiffs who clearly are not the intended beneficiaries of federal statutes often assert preemption claims. *See, e.g., Gade v. National Solid Wastes Mgmt. Ass'n*, 505 U.S. 88, 93-94, 108-09 (1992) (Occupational Safety and Health Act preempts state regulation of

(*continued* . . .)

Finally, even if the appropriate zone-of-interests analysis were to focus on the Medicaid Act rather than the Supremacy Clause, the text of §30(A) makes clear that both Medicaid beneficiaries and providers are among those Congress intended to protect, which is more than necessary to overcome a prudential standing challenge. *See Clarke v. Securities Indus. Ass'n*, 479 U.S. 388, 399-400 (1987) (zone-of-interests test "not meant to be especially demanding" and "there need be no indication of congressional purpose to benefit the would-be plaintiff"); *National Credit Union Admin. v. First Nat'l Bank & Trust Co.*, 522 U.S. 479, 488-89, 491-92, 499 (1998) (similar); *cf. Pennsylvania Pharmacists Ass'n v. Houstoun*, 283 F.3d 531, 538, 541, 544 (3d Cir. 2002) (en banc) (Alito, J.).

CONCLUSION

The judgment below should be affirmed.

Respectfully submitted,

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July 29, 2011

(. . . *continued*)
hazardous waste site employee training, testing, and licensing, in action brought by trade association of hazardous waste businesses); *California Fed. Sav. & Loan Ass'n v. Guerra*, 479 U.S. 272, 275-79, 291 (1987) (rejecting on merits employers' claim that state statute requiring pregnancy leave is preempted by Title VII as amended by Pregnancy Discrimination Act).

APPENDIX

Examples of Supremacy Clause Cases

Decided By This Court

In the 61 cases listed below, this Court decided claims for injunctive or declaratory relief initially brought in federal court against implementation of a state law on the ground that it conflicted with a federal statute or regulation, and thus was preempted under the Supremacy Clause. Based on our review, the preemption claims in these cases were not brought under 42 U.S.C. §1983; nor does it appear that the federal statutes involved contain the type of "rights-creating" language necessary to satisfy the test set forth in *Gonzaga University v. Doe*, 536 U.S. 273 (2002). There are numerous additional preemption cases decided by this Court that address Supremacy Clause injunction claims initially brought in state court.

1. *Chamber of Commerce of the U.S. v. Whiting*, 131 S. Ct. 1968 (2011) (business and civil rights groups sought declaratory and injunctive relief against state statute regulating employment of non-citizens unauthorized to work, claiming preemption by federal Immigration Reform and Control Act)

2. *Chamber of Commerce of the U.S. v. Brown*, 554 U.S. 60 (2008) (reversing denial of declaratory and injunctive relief in employers' action against state statute prohibiting recipients of certain state grants from using state funds to assist, promote, or deter union organizing, finding preemption by federal National Labor Relations Act)

3. *Rowe v. New Hampshire Motor Transp. Ass'n*, 552 U.S. 364 (2008) (affirming declaratory and injunctive relief in action by transportation groups against state

statute regulating tobacco shipments, as preempted by Federal Aviation Administration Authorization Act)

4. *Watters v. Wachovia Bank, N.A.*, 550 U.S. 1 (2007) (affirming declaratory and injunctive relief in bank's action against state laws governing subsidiaries of nationally chartered banks, as preempted by National Bank Act and related regulations)

5. *Arkansas Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S. 268 (2006) (affirming declaratory relief in action by Medicaid recipient against state statute requiring agency to assert lien in excess of medical expenses paid, as preempted by Medicaid Act)

6. *Engine Mfrs. Ass'n v. South Coast Air Quality Mgmt. Dist.*, 541 U.S. 246 (2004) (vacating Court of Appeals order affirming summary judgment against claims by diesel engine manufacturers, injured by reduced sales, seeking declaratory and injunctive relief against state regulation of vehicle fleets, finding regulations likely preempted at least in part by Clean Air Act, and remanding for lower courts to determine specifically which regulations were preempted)

7. *Pharmaceutical Research & Mfrs. of Am. v. Walsh*, 538 U.S. 644 (2003) (pharmaceutical manufacturer association sought injunction against state statute implementing prescription drug rebate program, claiming preemption by federal Medicaid Act)

8. *Kentucky Ass'n of Health Plans, Inc. v. Miller*, 538 U.S. 329 (2003) (HMOs sued for declaratory and injunctive relief against state statute that impaired insurers' discretion to contract selectively with health care providers, claiming ERISA preemption)

9. *City of Columbus v. Ours Garage & Wrecker Serv., Inc.*, 536 U.S. 424 (2002) (towing company sought

declaratory and injunctive relief against municipal ordinance regulating tow trucks, claiming preemption by federal Interstate Commerce Act)

10. *Verizon Md., Inc. v. Public Serv. Comm'n of Md.*, 535 U.S. 635 (2002) (concluding that doctrine of *Ex parte Young* permits telecommunications company's suit for declaratory and injunctive relief against state commission order requiring payments to competitor, claiming preemption by federal Telecommunications Act of 1996)

11. *Lorillard Tobacco Co. v. Reilly*, 533 U.S. 525 (2001) (reversing denial of declaratory relief in action by tobacco manufacturers and sellers against state regulations restricting sale and marketing of tobacco products, finding preemption by Federal Cigarette Labeling and Advertising Act)

12. *Crosby v. National Foreign Trade Council*, 530 U.S. 363 (2000) (affirming summary judgment for association of companies engaged in foreign commerce who sought declaratory and injunctive relief against state statute restricting trade with Burma, finding preemption by federal Foreign Operations, Export Financing, and Related Programs Appropriations Act)

13. *United States v. Locke*, 529 U.S. 89 (2000) (reversing denial of declaratory and injunctive relief in action by trade association of oil tanker operators against state regulations governing tanker operations, finding preemption by federal Ports and Waterways Safety Act)

14. *Foster v. Love*, 522 U.S. 67 (1997) (affirming Court of Appeals order reversing denial of injunction in voters' suit for declaratory and injunctive relief against state primary system, finding preemption by federal election statutes)

15. *De Buono v. NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806 (1997) (trustees of ERISA-regulated health

plans sought injunction against state tax on medical centers, claiming ERISA preemption)

16. *California Div. of Labor Standards Enforcement v. Dillingham Constr., N. Am., Inc.*, 519 U.S. 316 (1997) (contractors sought declaratory relief against state statute limiting payment of wages below prevailing wage rate in public contracts to apprentices in state-approved programs, claiming ERISA preemption)

17. *Dalton v. Little Rock Family Planning Servs.*, 516 U.S. 474 (1996) (per curiam) (remanding for entry of narrower injunction, in action by Medicaid providers seeking declaratory and injunctive relief against state constitutional amendment prohibiting use of state funds for abortions, as preempted by Social Security Act and Hyde Amendment)

18. *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995) (insurers sought injunction against state statute that imposed surcharges on hospital rates for patients of certain insurance carriers, claiming ERISA preemption)

19. *Building & Const. Trades Council of the Metro. Dist. v. Associated Builders & Contractors of Mass./R.I., Inc.*, 507 U.S. 218 (1993) (organization representing nonunion employers sought declaratory and injunctive relief against provision in state agency's project bid solicitation, claiming preemption by the National Labor Relations Act)

20. *District of Columbia v. Greater Wash. Bd. of Trade*, 506 U.S. 125 (1992) (affirming Court of Appeals reversal of district court denial of injunction in employer's action against District of Columbia statute regulating health care coverage, finding ERISA preemption)

21. *Gade v. National Solid Wastes Mgmt. Ass'n*, 505 U.S. 88 (1992) (affirming order of Court of Appeals in action

for declaratory and injunctive relief by trade association against state statute regulating employees handling hazardous waste, finding preemption by Occupational Safety and Health Act and related regulations)

22. *Morales v. Trans World Airlines*, 504 U.S. 374 (1992) (affirming declaratory and injunctive relief directed at certain state guidelines governing airfare advertising, as preempted by federal Airline Deregulation Act, in suit by airlines)

23. *Puerto Rico Dep't of Consumer Affairs v. Isla Petroleum Corp.*, 485 U.S. 495 (1988) (oil refineries and wholesalers sought declaratory and injunctive relief against Puerto Rico agency orders regulating oil prices, claiming preemption by federal Emergency Petroleum Allocation Act)

24. *Schneidewind v. ANR Pipeline Co.*, 485 U.S. 293 (1988) (affirming declaratory judgment against state statute requiring state approval for natural gas companies to issue securities, finding preemption by federal Natural Gas Act)

25. *California Coastal Comm'n v. Granite Rock Co.*, 480 U.S. 572 (1987) (mining corporation sought declaratory and injunctive relief against state permit requirement, claiming preemption by federal Coastal Zone Management Act, other federal land use statutes, and United States Forest Service regulations)

26. *California Fed. Sav. & Loan Ass'n v. Guerra*, 479 U.S. 272 (1987) (employer sued for declaratory and injunctive relief against state statute requiring reinstatement of employees after pregnancy leave, claiming preemption by Title VII of the Civil Rights Act of 1964)

27. *Wisconsin Dep't of Indus., Labor & Human Relations v. Gould Inc.*, 475 U.S. 282 (1986) (affirming

declaratory and injunctive relief obtained by debarred business against state statute penalizing repeat violators of the National Labor Relations Act (NLRA), as preempted by the NLRA itself)

28. *Hillsborough County, Fla. v. Automated Med. Labs., Inc.*, 471 U.S. 707 (1985) (operator of plasma centers sought declaratory and injunctive relief against ordinance regulating plasma collection, claiming preemption by Food and Drug Administration regulations)

29. *Lawrence County v. Lead-Deadwood Sch. Dist.*, 469 U.S. 256 (1985) (approving of federal court preemption injunction action and holding state statute regulating distribution of funds preempted by Payment in Lieu of Taxes Act)

30. *Brown v. Hotel & Rest. Emps. & Bartenders Int'l Union Local 54*, 468 U.S. 491 (1984) (union and its president sued for declaratory and injunctive relief against state law regulating unions representing casino employees, claiming preemption by National Labor Relations Act)

31. *Capital Cities Cable, Inc. v. Crisp*, 467 U.S. 691 (1984) (reversing Court of Appeals order that dissolved injunctions and reversed declaratory judgments, in action by cable television operators against state ban on broadcast advertising of alcoholic beverages, finding preemption by Federal Communications Commission regulations)

32. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983) (affirming in part declaratory and injunctive relief in employers' suit against state law prohibiting pregnancy discrimination in employee benefits plans, finding ERISA preemption)

33. *Pacific Gas & Elec. Co. v. State Energy Res. Conservation & Dev. Comm'n*, 461 U.S. 190 (1983) (utility com-

panies sued for declaratory and injunctive relief against state statute that conditioned construction of nuclear power plants on availability of adequate storage and disposal facilities, claiming preemption by federal Atomic Energy Act and related regulations)

34. *Edgar v. Mite Corp.*, 457 U.S. 624 (1982) (corporation sought declaratory and injunctive relief against state securities law, claiming preemption by federal Williams Act)

35. *New York Tel. Co. v. New York State Dep't of Labor*, 440 U.S. 519 (1979) (employers sued for declaratory and injunctive relief against state statute that provided for unemployment benefits to striking workers, claiming preemption by National Labor Relations Act and Social Security Act)

36. *New Motor Vehicle Bd. of Cal. v. Orrin W. Fox Co.*, 439 U.S. 96 (1978) (automobile manufacturer and franchisees sought declaratory and injunctive relief against state statute requiring agency approval to open new retail dealerships, claiming preemption by Sherman Act)

37. *Malone v. White Motor Corp.*, 435 U.S. 497 (1978) (employer sued for declaratory and injunctive relief against state statute imposing pension funding charge on certain employers, claiming preemption by National Labor Relations Act)

38. *Ray v. Atlantic Richfield Co.*, 435 U.S. 151 (1978) (affirming in part declaratory and injunctive relief in tanker vessel operators', owners', and customers' suit against state statute regulating oil tanker design, finding preemption by federal Ports and Waterways Safety Act of 1972)

39. *Douglas v. Seacoast Prods., Inc.*, 431 U.S. 265 (1977) (affirming declaratory and injunctive relief in federal

license holders' suit against state statute restricting licensing of state fishing vessels to United States citizens and state residents, finding preemption by federal Enrollment and Licensing Act)

40. *Jones v. Rath Packing Co.*, 430 U.S. 519 (1977) (affirming declaratory and injunctive relief in meat processor's and flower millers' suit against state statute and regulation governing labeling of packaged foods, finding preemption by Federal Meat Inspection Act and Fair Packaging and Labeling Act)

41. *City of Burbank v. Lockheed Air Terminal, Inc.*, 411 U.S. 624 (1973) (affirming lower court opinion finding plaintiffs entitled to injunction against municipal noise ordinance banning night flights, finding preemption under Federal Aviation Act)

42. *Askew v. American Waterways Operators, Inc.*, 411 U.S. 325 (1973) (ship and oil terminal owners and operators and shipping associations sought declaratory and injunctive relief against state statute governing oil spill liability, claiming preemption by Water Quality Improvement Act and Admiralty Extension Act)

43. *Perez v. Campbell*, 402 U.S. 637 (1971) (reversing denial of declaratory and injunctive relief against state statute automatically suspending driver's license based on nonpayment of judgments, finding preemption by Bankruptcy Act)

44. *California Dep't of Human Res. Dev. v. Java*, 402 U.S. 121 (1971) (affirming injunction against state statute regarding timing of unemployment insurance benefits suspension pending employer appeals of eligibility determinations, finding preemption by Social Security Act)

45. *Rosado v. Wyman*, 397 U.S. 397 (1970) (remanding for lower court to enter declaratory relief and injunction against state public benefits plan as preempted by Social

Security Act, if state did not timely develop alternate plan)

46. *Railroad Transfer Serv., Inc. v. City of Chicago*, 386 U.S. 351 (1967) (reversing denial of declaratory and injunctive relief in motor carrier's suit against city ordinance requiring license to operate commercial vehicles, finding preemption by federal Interstate Commerce Act)

47. *Florida Lime & Avocado Growers, Inc. v. Paul*, 373 U.S. 132 (1963) (avocado growers sought declaratory and injunctive relief against state statute governing avocado certification, claiming preemption by Agricultural Adjustment Act and related regulations)

48. *Kesler v. Department of Pub. Safety, Fin. Responsibility Div., Utah*, 369 U.S. 153 (1962) (bankrupt sought declaratory and injunctive relief against state statute revoking motor vehicle license and registration, claiming preemption by Bankruptcy Act)

49. *Campbell v. Hussey*, 368 U.S. 297 (1961) (affirming injunction against state statute requiring that certain strains of tobacco be labeled, finding preemption by Tobacco Inspection Act and implementing regulations, in suit by tobacco auction warehouse owners)

50. *Public Utils. Comm'n of Ohio v. United Fuel Gas Co.*, 317 U.S. 456 (1943) (affirming injunction in suit against state commission's orders setting natural gas transport rates, finding preemption by Natural Gas Act of 1938)

51. *Parker v. Brown*, 317 U.S. 341 (1943) (raisin producer sued for injunctive relief against state statute requiring diversion of raisins into surplus and stabilization pools, claiming preemption by Sherman Act and Agricultural Marketing Agreement Act of 1937)

52. *Cloverleaf Butter Co. v. Patterson*, 315 U.S. 148 (1942) (reversing denial of injunction against state statute allowing seizure of food products, finding preemption by federal law governing food inspection, codified in Internal Revenue Code and related regulations)

53. *Hines v. Davidowitz*, 312 U.S. 52 (1941) (affirming injunction against state law requiring non-citizens to register and carry identification, finding preemption by Alien Registration Act of 1940)

54. *Mintz v. Baldwin*, 289 U.S. 346 (1933) (cattle company sought injunction against state order that required certification of disease-free cattle, claiming preemption by federal statute governing shipments from quarantined areas)

55. *Clallam County, Wash. v. United States*, 263 U.S. 341 (1923) (holding for plaintiff corporation in suit seeking decree against state and local tax, finding corporation to be an instrumentality for carrying out war formed under federal Act of July 9, 1918, and thus not subject to state taxation)

56. *Choctaw, Okla., & Gulf R.R. Co. v. Harrison*, 235 U.S. 292 (1914) (reversing denial of injunction against state taxation of railroad operating mines on land leased from Choctaw and Chickasaw Indians, finding railroad to be federal instrumentality not subject to taxation under Curtis Act of 1898)

57. *Cummings v. City of Chicago*, 188 U.S. 410 (1903) (landowners sought declaration of rights, and injunction against municipal ordinance requiring permit for dock construction, claiming preemption by River and Harbor Act of March 3, 1899)

58. *Railway Co. v. McShane*, 89 U.S. (22 Wall.) 444 (1874) (affirming injunction against county taxation of certain property, as preempted by federal Act of July 2, 1864)

59. *Union Pac. R.R. Co. v. Peniston*, 85 U.S. (18 Wall.) 5 (1873) (railroad created by federal Act of July 1, 1862 filed bill to restrain county taxation of certain property, claiming preemption by federal Act of July 2, 1864)

60. *Gilman v. City of Philadelphia*, 70 U.S. (3 Wall.) 713 (1865) (coal wharves owner sought injunction against state law authorizing construction of bridge over river, claiming preemption by federal Act of February 18, 1793, which authorized vessels enrolled and licensed according to its provisions to engage in coasting trade)

61. *Osborn v. Bank of the U.S.*, 22 U.S. (9 Wheat.) 738 (1824) (affirming injunction obtained by Bank of the United States against state tax, finding preemption by federal statute creating the Bank)

RECORD
AND
BRIEFS

Supreme Court, U.S.
FILED
JUL 29 2011
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Nos. 09-958, 09-1158, and 10-283

In The
Supreme Court of the United States

TOBY DOUGLAS, Director,
California Department of Health Care Services,

Petitioner,

v.

INDEPENDENT LIVING CENTER OF
SOUTHERN CALIFORNIA, INC., *et al.*,

Respondents.

TOBY DOUGLAS, Director,
California Department of Health Care Services,

Petitioner,

v.

CALIFORNIA PHARMACISTS ASSOCIATION, *et al.*,

Respondents.

TOBY DOUGLAS, Director,
California Department of Health Care Services,

Petitioner,

v.

SANTA ROSA MEMORIAL HOSPITAL, *et al.*,

Respondents.

On Writs Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

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QUESTION PRESENTED

Whether the Supremacy Clause supports an equitable cause of action under the Constitution, to prevent injury to Medicaid beneficiaries and providers, by enjoining state officials to refrain from implementing state legislation that contravenes 42 U.S.C. § 1396a(a)(30)(A) of the federal Medicaid Act.

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The wording of Section 30A clearly prohibited the State from reducing provider payments for purely budgetary reason; and, there is no "vague or amorphous" or "broad and non-specific" language in Section 30A which authorizes the State to reduce Medicaid provider payments for purely budgetary reasons, or counsels against injured beneficiaries or providers defending themselves in court whenever the State cuts provider payments for purely budgetary reasons – in flat and deliberate violation of the quality and equal access clauses of Section 30A 57

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PART ONE

PROCEEDINGS BELOW

The respondents in the two *Independent Living Center* ("ILC") cases in 09-958 and 09-1158 are two disabled Medicaid beneficiaries; three pharmacies who participate in the Medicaid program; and an independent living center and two Gray Panther groups who were the plaintiffs below.[1]

The various providers and organizations who were plaintiffs below, sued on behalf of themselves and for the benefit of the thousands of Medicaid beneficiaries who are their patients, clients, or members, as the case may be.

The respondents in the ILC cases in 09-958 and 09-1158 shall sometimes be referred to, collectively, as the "ILC plaintiffs."

Also, the ILC plaintiffs who are Medicaid beneficiaries, and the Medicaid beneficiaries who are the patients, clients, and members of the other ILC

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[1] The party respondents filing this brief in 09-958 are Independent Living Center of Southern California, Inc.; Margaret Dowling; Mark Beckwith; Gerald Shapiro, Pharm.D., dba Uptown Pharmacy & Gift Shoppe; Sharon Steen, dba Central Pharmacy; Tran Pharmacy, Inc.; Gray Panthers of San Francisco; and Gray Panthers of Sacramento.

The party respondents filing this brief in 09-1158 are Independent Living Center of Southern California, Inc.; Gerald Shapiro, dba Uptown Pharmacy & Gift Shoppe; Sharon Steen, dba Central Pharmacy; and Tran Pharmacy, Inc.

plaintiffs, shall sometimes be referred to, collectively, simply as "beneficiaries."

And, the ILC plaintiffs who are pharmacies who serve beneficiaries shall sometimes be referred to as "providers."

THE MEDICAID PROGRAM

The Medicaid Act is a federal-state funded health services program, whose purpose is to enable the poor in this country to have access to the same minimum level of medical care as do the non-poor, called "mainstream medicine."

The Act, and the Medicaid fee-for-service program in California (called "Medi-Cal") are described in other briefs in these consolidated cases; hence need no repeat description in this brief.

PROCEDURAL STATEMENT IN RE 09-958

Since before 2008 a payment schedule ("Base Fee Schedule") has existed in the Medi-Cal program to pay the various providers in the fee-for-services part of the federal-state Medicaid program in California, called "Medi-Cal."

In February 2008 the California Legislature enacted Assembly Bill ("AB 5") which required the Director to withhold ten percent from all payments to

providers in the Medi-Cal fee-for-service program for services on or after July 1, 2008.

A petition for a writ of mandamus was filed by the ILC plaintiffs in state court, under the Supremacy Clause, to prevent injury to the beneficiary and provider plaintiffs, and to the thousands of beneficiaries who are the patients, clients, and members of the plaintiff pharmacies, independent living center, and Gray Panther groups.

The suit was removed by the Director to the federal court.[2] On June 25, 2008, the district court denied the ILC plaintiffs' motion for preliminary injunction to enjoin the Director from implementing AB 5. Joint App. 139, 125-139.

On July 11, 2008, the appeals court reversed;[3] followed by a full opinion on September 17, 2008.[4]

NOTE: This September 17, 2008, opinion became, formally or informally, the law of the case, so as to be the decision upon which all the subsequent rulings in the ILC cases in 09-958 and 09-1158 were based (whether or not the subsequent district court and appeals court decisions make any reference to the

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[2] Doc. 1 (Joint App. 1).

[3] *Independent Living Center v. Shewry*, 543 F.3d 1047 (9th Cir. 2008).

[4] 09-958 Pet. App. 58-93; also, same decision: 543 F.3d 1050 (9th Cir. 2008), *cert. denied*, 129 S.Ct. 2828 (2009).

initial, controlling, September 17, 2008, appeals court opinion).

Also, this September 17, 2008, decision became, by default, the *ratio decidendi* of all the other cases in 09-1158, which are but followers of the lead case, 09-958.

Subsequent procedural history in 09-958

On August 18, 2008, the district court, on remand, granted the ILC plaintiffs a preliminary injunction to enjoin the Director from implementing the preempted AB 5, including refraining from withholding ten percent from payments to certain providers for services after July 1, 2008.[5]

This was a negative injunction, not an affirmative injunction.

The district court found that AB 5 was enacted, contrary to Section 30A, for purely budgetary reasons,[6] as alleged by the ILC plaintiffs,[7] and that the

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[5] The August 18, 2008 order provided in relevant part:

"The Court hereby orders the respondent Director . . . to refrain from enforcing Cal. Welf. & Inst. Code § 14105.19(b)(1), including refraining from reducing by ten percent payments under the Medi-Cal fee-for-service program for physicians, dentists, pharmacies, adult day care health care centers, clinics, . . . for services provided on or after July 1, 2008."

09-958 Pet. App. 124, 94-124.

[6] 09-958 Pet. App. 106-108, and 107 n. 10.

beneficiaries and pharmacies who were plaintiffs, and the thousands of beneficiaries who were patients, clients, and members of several of the ILC plaintiffs, would be injured irreparably if preliminary injunction were not granted,[8] as alleged by the ILC plaintiffs.[9]

The declarations of the ILC plaintiff beneficiaries and the plaintiff pharmacies, independent living center, and Gray Panther groups showed the irreparable harm threatened to them as beneficiaries and to the thousands of beneficiaries whom the plaintiff providers serve.[10]

On August 27, 2008, the district court amended the August 18, 2008, order to provide that it not apply retroactively to July 1, 2008.[11]

The appeals court affirmed the August 18, 2008, preliminary injunction, but reversed the subsequent August 27, 2008, order – so that the August 18, 2008,

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[7] First amended complaint ("FAC"), 09-958; set forth in Pars. 45-46, at Joint App. 109-111.

[8] The irreparable injury to the ILC plaintiffs, and to the thousands of beneficiaries who are the patients, clients, and members of various of the ILC plaintiffs is set forth in detail in the findings. 09-958 Pet. App. 108-120.

[9] Irreparable injury was pleaded in detail in the FAC. Joint App. 99-108, 112.

[10] These declarations, are set forth in the Excerpts of Record as Documents 102, 98, 95, 88, 86, 84, 83, 82, 81, 80, 56, 55, 54, 53, 52, 51, 50, 15, 14, 13, and 1, in *Independent Living Center v. Shewry*, Appeal No. 08-56422, Ninth Circuit.

[11] 09-958 Pet. App. 125-126.

order applied retroactively to July 1, 2008, the operative date of AB 5.

(**NOTE:** This retroactivity of the initial August 18, 2008 preliminary injunction is not challenged before this Court.)[12]

The home health and NEMT services injunction in 09-958

On November 17, 2008, a second negative preliminary injunction was issued in 09-958 which enjoined the Director from implementing AB 5 in respect to home health agencies, and non-emergency medical transporters ("NEMT").

This negative injunction tracked the wording of the initial August 18, 2008, order, except that it was

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[12] The appeals court found on the cross-appeal by the ILC plaintiffs that the State waived sovereign immunity because (1) the State statute which permits mandamus against State officials for refund of moneys unlawfully withheld, and (2) the Director in removing the 09-958 action to district court, therein waived the State's sovereign immunity in the 09-958 case. See, 09-958 Pet. App. 29-38.

The ILC plaintiffs' position in the district court was, also, that the ILC initial motion was timely and an order would have issued in June, 2008 to restrain implementing AB 5, but for the error invited by the Director; so that the August 18, 2008 order should in equity, and by estoppel, operate *nunc pro tunc* so as to be deemed effective before July 1, 2008. (See Excerpts of Record, Document 12, in *Independent Living Center v. Shewry*, Appeal No. 08-56422, Ninth Circuit.)

only effective from the date of the order, November 17, 2008, prospectively.[13]

The findings again found that AB 5 violated Section 30A, due to being enacted solely for budgetary reasons, 09-958 Pet. App. 144-145.

The district court also found, upon the declarations, that in addition to its findings in the August 18, 2008 order, that as a result of the payment reduction to home health agencies and NEMT transporters, that beneficiaries were being denied access to home health and NEMT transportation services throughout the state. 09-958 Pet. App. 147-151.

On July 9, 2009, the appeals court affirmed the August 18, 2008 preliminary injunction, 09-958 Pet. App. 2-29, 38.

The same July 9, 2009, decision also reversed the August 27, 2008, order which had denied retroactivity

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[13] The November 17, 2008 order provided:

> The Court hereby orders the respondent Director, her agents, servants, employees, attorneys, successors, and all those working in concert with her to refrain from enforcing Cal. Welf. & Inst. Code § 14105.19(b)(1), including refraining from reducing by ten percent payments under the Medi-Cal fee-for-service program for NEMT and home health services provided on or after November 17, 2008.

09-958 Pet. App. 153. (See findings, 09-958 Pet. App. 139-153).

of the injunction for the period of July 1, 2008 to August 18, 2008. 09-958 Pet. App. 29-38.[14]

On August 7, 2009, the appeals court affirmed the November 17, 2008, preliminary injunction. 09-958 Pet. App. 54-57.

The appeals court and the parties did not, in the latter two appeals in 09-958, revisit the issues which are the subject of the First Question Presented, because manifestly those same issues had been ruled upon by the appeals court in its September 17, 2008, opinion, which preceded the two appeals of the Director which are today the subject of 09-958.

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[14] See n. 11 of this brief. I.e., the appeals court concluded that the State, in the state procedural statute under which the ILC plaintiffs sued in state court, waived the State's immunity to suits in respect to retroactive monetary obligations; and, that State immunity to suit for retroactive payments was also waived by the removal of the state suit, in 09-958, to federal court.

Again, violation of State sovereignty as to these retroactive payments, in respect to services furnished between July 1, 2008 and August 18, 2008, the date of the preliminary injunction in 09-958, is not a subject of contention in these certiorari proceedings.

PROCEDURAL STATEMENT IN RE 09-1158

The State legislature enacts AB 1183, a five percent payment reduction to pharmacies, to replace AB 5 eff. March 1, 2009: again, for solely budgetary reasons, again, in violation of Section 30A

The California Legislature then enacted Assembly Bill ("AB") 1183 to terminate AB 5 in respect to Medicaid services furnished after February 2009.[15]

AB 1183 also enacted a successor provider payment reduction for Medicaid services furnished on or after March 1, 2009 – again, purely for budgetary reasons.[16]

The arbitrary reduction in payment to pharmacies, this time, was five percent, under AB 1183. (09-1158 Pet. App. 206).

The same ILC plaintiffs then filed a new complaint under the Supremacy Clause, which alleged, again, that the new AB 1183 was contrary to hence preempted by Section 30A, for the same reason as AB 5: that it was enacted solely for budgetary reasons,

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[15] This part of AB 1183 is set forth at 09-1158 Pet. App. 201-204.

[16] This part of AB 1183, which enacted the new payment-reducing State law, Cal. Welf. & Inst. Code § 14105.191, is set forth at 09-1158 Pet. App. 205-217.

contrary to Section 30A,[17] which would injure them and the beneficiaries who were their patients and clients, irreparably.[18] They again requested injunctive relief to prevent irreparable injury.

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[17] Par. 24 alleged (Joint App. 150), that:

> (T)he State's sole purpose, and the conclusive factor, in enacting the 5% Rate Reduction was to reduce the budget deficit.

Par. 25 alleged that:

> Accordingly, . . . the action of the Legislature to enact the aforesaid provisions of § 14105.191 Welf. & Inst. Code, and the 5% Rate Reduction in respect to Pharmacy providers, were contrary to and in violation of the quality and access provisions of Section 30A, such that the Defendant Director will be acting in excess of and without jurisdiction to implement § 14105.191 Welf. & Inst. Code, including the 5% Rate Reduction for Pharmacy providers, commencing March 1, 2009.

[18] Par. 21 (Joint App. 148-149) alleged that:

> Further, unless restrained . . . the defendant Director will implement the aforesaid 5% Rate Reduction . . . which in turn will thereby result in injury to the Plaintiffs; to . . . [pharmacies] . . . and to their Medi-Cal patients – which injury will foreseeably result in Pharmacy providers . . . not accepting new Medi-Cal patients, or stopping serving Medi-Cal patients at all, or by reducing kinds, amounts, locations and levels of services to Medi-Cal beneficiaries, or by going out of business, so that thereby Medi-Cal beneficiaries . . . will be caused and threatened to be caused, denial and reduction of access to life-vital Pharmacy services and treatment in the Medi-Cal FFS program, resulting in great physical suffering and injury to beneficiaries who are patients of Plaintiffs . . . ; all to [their] irreparable injury[.]

The ILC plaintiffs' motion for preliminary injunction[19] was supported by declarations showing irreparable injury to beneficiaries and providers which was threatened by the new payment reduction law, AB 1183.[20]

On February 27, 2009, the district court:

- ruled that the new State law had been enacted for purely budgetary reasons, contrary to Section 30A;[21]
- found that irreparable harm to both beneficiaries and providers would result,[22] and,
- issued a negative injunction, ordering the Director to refrain from implementing AB 1183 in respect to pharmacies,

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[19] Joint App. 39 (being Docket No. 10 in the district court).

[20] These declarations are set forth in Document 11 in the Docket of *Independent Living Center v. Maxwell-Jolly*, 2:09-cv-0382, C.D. Cal.

[21] 09-1158 Pet. App. 143.

The district court found:

> Here the legislative history shows no indication that the Legislature considered any of the relevant factors before implementing AB 1183. Instead, it appears that the Legislature enacted the rate reduction purely for budgetary reasons.

[22] 09-1158 Pet. App. 143-149.

> including refraining from reducing by five percent payments to pharmacies for prescription drugs.

09-1158 Pet. App. 151.

The new injunction tracked the language of the first injunction, so as to be a negative injunction.[23]

On March 3, 2010, the appeals court affirmed the February 27, 2009, preliminary injunction to enjoin implementation of the five percent deduction from pharmacy payments, of AB 1183 (09-1158 Pet. App. 53-58) in a short ruling that the Director failed to show any error in the district court's findings and conclusions. 09-1158 Pet. App. 53-58.

Thus, the appeals court affirmed the district court's rulings that the State Legislature enacted the AB 1183 reduction in provider payments, contrary to supreme federal law, Section 30A, for purely budgetary reasons; and that the reduction would injure providers directly by impacting the amounts paid to

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[23] The February 27, 2009 order provided:

> The Court hereby orders the respondent Director, his agents, servants, employees, attorneys, successors, and all those working in concert with him to refrain from enforcing Cal. Welf. & Inst. Code § 14105.191(b)(3), as modified by AB 1183 beginning on March 1, 2009, by refraining from reducing by five percent payments to pharmacies for prescription drugs and traditional over-the-counter drugs provided by prescriptions) provided under the Medi-Cal fee-for-service program.

09-1158 Pet. App. 151.

them, and, would adversely impact access of beneficiaries to prescription drugs in the State's Medicaid program.

Again, the parties and the appeals court did not, in this appeal in re AB 1183, revisit the issues which are the subject of the First Question Presented, because manifestly those same issues had been ruled upon by the appeals court in its September 17, 2008, opinion, and bound the result.

* * *

NOTE: The 09-983 case has not been rendered moot by the termination by the State Legislature of AB 5 effective at the close of February 2011.

Neither has the 09-1158 case been rendered moot by either of two State laws, AB 97, sections 93.2 and 93.5, which are mentioned by the Intervenors in 09-958 as having been recently enacted by the State Legislature, in March and June of 2011.

This is because voluntary termination of the preempted implementation by the State of AB 5 or AB 1183 by the passage of the new State laws mentioned by the Intervenors, would still leave unresolved the question, in the final analysis, of whether the Director is entitled to recoupment of the amounts ordered by the district court to be paid to providers.

NOTE ALSO: In November 2010 the federal Centers for Medicare and Medicaid Services ("CMS")

did deny the State Plan Amendments ("SPAs") submitted by the California Dept. of Health Care Services ("DHCS") to CMS for approval of the AB 5 and AB 1183 Medicaid provider payment reductions.

These rulings are not any final ruling against the State, because DHCS filed an administrative appeal.

A briefing schedule has been set which takes the appeal through November 2011, before any final decision will be made by the Secretary on this DHCS appeal.

Hence, nothing has happened so far in the administrative proceedings between the Secretary and DHCS, which is any cause for the ILC cases in 09-958 and 09-1158 to be stayed, or for the Court to surrender jurisdiction over the causes in the ILC cases, to the Secretary, in any way.

PART TWO

A. THE GENERAL HISTORY OF LITIGATION UNDER THE MEDICAID ACT

The "pre-1983" period

Before it became recognized in 1980 that the "laws" in 42 U.S.C. § 1983 included the Medicaid Act, suits by beneficiaries and providers under the Supremacy Clause to obtain injunctive or declaratory relief, to prevent being injured from a State's violation of the Medicaid Act were commonplace.

See, the following Supremacy Clause cases, before § 1983 came into use in 1980:

Eligibility rules change:

- *Bass v. Rockefeller,* 331 F.Supp. 945 (S.D.N.Y. 1971).
- *Webb v. Aggrey,* 447 F.Supp. 17 (W.D. Ohio 1977).

Payments to nursing homes:

- *Harmony Nursing Home, Inc. v Anderson,* 341 F.Supp. 957, 958 (D. Minn. 1972).

Inclusion of eye-glasses:

- *White v. Beal*, 555 F.2d 1146 (3d Cir. 1977).

Transportation services:

- *Smith v. Vowell,* 379 F.Supp. 139 (D. Tex. 1974).

Payments to health care facilities:

- *Minn. Assn. of Health Care Facilities v. Minn. Dept. of Public Welfare,* 602 F.2d 150, 154 (8th Cir. 1979).

Supplemental benefit:

- *Hayes v. Stanton,* 512 F.2d 133 (7th Cir. 1975).

The "§ 1983 period"

Medicaid beneficiaries and providers sued under § 1983 once it became available in 1980, by the *Thibotout* decision.[24]

This fashionable use of § 1983 was not because Congress commanded its use or prohibited any Supremacy Clause suit to be filed, but because 42 U.S.C. § 1988, permitted attorneys' fees to be awarded in a § 1983 case, but not if the pleader sued only under the Supremacy Clause.

"Post-1983" Medicaid actions

More recently –when a number of Circuits "abolished" § 1983 suits in respect to Section 30A – the Medicaid litigation bar simply returned to their horse-and-buggy vehicle – the Supremacy Clause cause of action – which they had prior used, long before the sleek Cadillac § 1983 jurisdictional vehicle came into, and went out of, use.

B. THE HISTORY OF SECTION 30A LITIGATION

The litigation in respect to Section 30A, both in California and elsewhere, is set forth below.

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[24] *Maine v. Thibotout,* 448 U.S. 1 (1980).

Section 30A:

- *Illinois Hospital Assn. v. Illinois Dept. of Pub. Aid,* 576 F.Supp. 360, 368-369 (N.D. Ill. 1983) (provider payment reduction, based solely on budgetary considerations, enjoined);

- *California Hospital Assn. v. Schweiker,* 559 F.Supp. 110, 114 (C.D. Cal. 1982) (provider payment limit, based solely on budgetary considerations, enjoined);

- *Arkansas Medical Society, Inc. v. Reynolds,* 6 F.3d 519, 531 (8th Cir. 1993) (provider payment reduction, based solely on budgetary considerations, enjoined);

- *Wisconsin Hospital Assn. v. Reivitz,* 733 F.2d 1226, 1236 (7th Cir. 1984) (provider payment limit, based solely on budgetary considerations, enjoined);

- *Clayworth v. Bonta,* 295 F.Supp.2d 1110, 1119 (E.D. Cal. 2003) (five percent provider payment reduction, based solely on budgetary considerations, enjoined) *rev'd,* for not qualifying as a § 1983 suit (9th Cir. 2004);

- *ILC v. Shewry,* 543 F.3d 1050 (9th Cir. 2008), AB 5 case (ten percent provider payment reduction, based solely on budgetary considerations, enjoined);

- *ILC v. Maxwell-Jolly,* 09-1158 App. 53 (9th Cir. 2010), AB 1183 case (five percent

provider payment limit, based solely on budgetary considerations, enjoined);

– *Cal. Pharm. v. Maxwell-Jolly,* 563 F.3d 847 (9th Cir. 2009), AB 1183 case (provider payment limit, based solely on budgetary considerations, enjoined).

In each of these cases the facts are always the same: the State legislature enacted a State law, solely for budgetary reasons, to reduce payments to the Medicaid providers in the State – which is promptly enjoined by a federal court, for violating the quality and equal access provisions of supreme federal law, Section 30A.

There is no question, under this unbroken line of decisions, that the quality and equal access clauses of Section 30A are violated whenever a State legislature reduces a Medicaid provider payment rate **for solely budgetary reasons**.

In any event, such suits by beneficiaries and providers (on their own account and as representatives of their Medicaid patients), to obtain compliance of a State with the minimum provider payment requirements of federal law are routinely filed today under the Supremacy Clause, just as other Supremacy Clause cases were routinely filed by the Medicaid litigation bar, long before §1983 was "discovered."

Congress, with knowledge that Supremacy Clause actions are litigated, has never acted to stop them. This signifies Congressional approval, not disapproval, of Supremacy Clause actions of the sort filed by the ILC plaintiffs in the ILC cases at bar

Congress was well aware throughout all the 13-year period before *Thibotout* was decided in 1980, that beneficiaries and providers were using the Supremacy Clause to prevent being injured from the usual State violations of the Medicaid Act.

Congress is well aware today, that these Supremacy Clause suits are being filed all over the country.

Congress' silence in face of this knowledge speaks approval, not disapproval, of such suits as the ILC suits at bar.

As reported by the Court in *Wilder v. Virginia Hospital Assn.*, 496 U.S. 498, 516-517 (1990):

> During the 1970's provider suits in the federal courts were commonplace. In addition, in response to several States freezing their Medicaid payments to health care providers, Congress amended the Act in 1975 to require the States to waive any Eleventh Amendment immunity from suit for violations of the Act. (*See,* H.R. Rep. No. 94-1122, p. 4 (1976); *see* also 121 Cong. Rec. 42259 (1975) (remarks of Sen. Taft). Congress believed the waiver necessary because the existing means of enforcement –

> noncompliance procedures instituted by the Secretary or suits for injunctive relief by health care providers – were insufficient to deal with the problem of outright noncompliance because they included no compensation for past underpayments. *See* H.R. Rep. No. 94-1112, *supra,* at 4. The amendment required the Secretary to withhold 10% of federal Medicaid funds from any State that had not executed a waiver of its immunity by March 31, 1976. Pub. L. 94-182, § 111, 89 Stat. 10545. The provision generated a great deal of opposition from the States and was repealed in the next session of Congress. Pub. L. 94-552, 90 Stat. 2540, *see* H.R. Rep. No. 94-1122, *supra,* at 4. But Congress explained that it did not intend the repeal to "be construed in any way contravening or constraining the rights of providers of Medicaid services, the State Medicaid agencies, or the Department to seek prospective, injunctive relief in a federal or a state judicial forum. Neither should the repeal of [the waiver section] be interpreted as placing constraints on the rights of parties involved to seek such prospective, injunctive relief."

As noted further by Alito, J., *Pennsylvania Pharmacists Assn. v. Houston,* 283 F.3d 531, 541 (3d Cir. 2002):

> (T)he House Committee Report on the 1981 amendments of (Section 30A) observed that

> "in instances where the States or the Secretary fail to observe these statutory requirements, **the courts would be expected to take appropriate remedial action.**" H.R. Report 97-158, vol. II, at 301 (1981).

(Boldface emphasis supplied).

Thus, Congress has never enacted any provision to prevent beneficiary or provider litigation in respect to the minimum requirements which States must comply with in setting Medicaid provider payment rates under Section 30A.

Hence, from the above, Congress has implicitly and expressly approved the Supremacy Clause cause of action in respect to State violations of Section 30A of the Medicaid Act, by never attempting to block its use by any Congressional enactments on the subject, and by comment in committee that Congress expected such litigation to be conducted, whenever a State failed to meet the minimum requirements, as in case at bar, of Section 30A.

The litigation history of Section 30A shows that it is Medicaid beneficiaries and providers, alone – not the Secretary at all – who customarily vindicate the supremacy of the Medicaid Act

The foregoing litigation history of Section 30A, set forth above, shows that for the life of the Act – and in the ILC cases – it has always been beneficiaries and providers – **never** the Secretary – who have

vindicated the federal interest in the supremacy of the Medicaid Act, against federally preempted State reductions of payments to Medicaid providers, contrary to Section 30A, which injure or threaten to injure access of beneficiaries to Medicaid services.

And again, it **has never been the Secretary**, in any of the reported cases – or in the ILC cases – who defended the ill, the aged, and the disabled beneficiaries in these cases: but, always, it has been, and still is in the ILC cases at bar, the beneficiaries and providers who bring to the attention of the federal court the fact of violations by States of the minimum payment requirements of federal law (Section 30A), and obtain the remedy of injunction against States' violations of this supreme federal law.

PART THREE

THE PRIMARY ISSUES OF THESE CASES

THE TWO CENTRAL ISSUES OF THESE CASES WERE RAISED, OR JOINED, IN THE FIRST MOTION OF THE ILC PLAINTIFFS FOR A PRELIMINARY INJUNCTION, TO ENJOIN THE DIRECTOR FROM IMPLEMENTING THE PREEMPTED STATE LAW, AB 5, IN 09-958

The precise base claims of the ILC plaintiffs under the Supremacy Clause, for a negative injunction to enjoin the Director from withholding ten percent from all payments to providers, commencing July 1,

2008, under State law, AB 5 (in 09-0958) are set forth in their amended petition for a writ of mandamus filed in the state court in the spring of 2008 (Joint App. 85-124). The action was removed by the Director to the district court. Joint App. 1, Document 1. See, first amended petition for mandamus. Joint App. 140-155.

These base claims are encapsulated in the ILC plaintiffs' memorandum in support of their initial motion for preliminary injunction,[25] of which a relevant part is set forth *en haec verba* below:

> The procedural violation was that the rates were reduced arbitrarily and capriciously, for budgetary reasons, without the Legislature considering whether the "reduction could be sustained by providers, in light of their costs, without a loss in quality or equal access for Medi-Cal recipients;" as required by the quality and access clauses of Sec. 30(A). (See, *Clayworth* [*v. Bonta*], *supra*, 295 F.Supp.2d at 1128.)
>
> Therein, under the Supremacy Clause as interpreted by the *Ex parte Young* line of decisions, not only is (1) the ten percent provider payment reduction statute (§§14105.19, subds. (a), (b)(1), (b)(2), and (c), and §14166.245, subd. (a), of the Welf. & Inst. Code), preempted by the contrary requirements of the

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[25] Joint App. 2. This Memorandum is Document 11 in the District Court Clerk's docket in 2:08-cv-03315, C.D. Cal.

quality and equal access clauses of Sec. 30(A), but, also (2) the above [seven] plaintiffs have an implied right to injunctive relief against the Director, who is threatening to injure them, and subjecting them to risk of injury, by implementing the preempted 10% payment cut to Medi-Cal managed care plans in violation of federal law, namely, Sec. 30(A) . . .

NOTE: In so suing, the [seven] plaintiffs in the First Cause of Action are not exercising any private right of action right under 42 U.S.C. § 1983, as a sword, to enforce Sec. 30(A), but, to the contrary, are instead invoking the protection of the Supremacy Clause, as a shield, as permitted them by the doctrine of *Ex parte Young*. As held in *Western Air Lines, Inc. v. Port Authority of New York and New Jersey*, 817 F.2d 222, 225 (2d Cir. 1987):

"[A] claim under the Supremacy Clause that a federal law preempts a state regulation is distinct from a claim for enforcement of that federal law."

and, as held by *Burgio and Campofelice, Inc. v. NYS Dept. of Labor*, 107 F.3d 1000, 1006 (2d Cir. 1997):

"Although there is some confusion in the cases, we agree with those commentators who have concluded that 'the best explanation of Ex parte Young and its progeny is that the Supremacy Clause creates an implied right of action for injunctive relief against state

officers who are threatening to violate the federal constitution or laws.'"

13B C. Wright, A. Miller & E. Cooper, Federal Practice & Procedure: Jurisdiction 2d, § 3566, at 102 (1984); see also *Guaranty Nat'l Ins. Co. v. Gates*, 916 F.2d 508, 512 (9th Cir. 1990) (quoting same). . . .

RELIEF REQUESTED IN THE FIRST CAUSE OF ACTION

The aforesaid [seven] plaintiffs, in the First Cause of Action, request a preliminary injunction to restrain the Director from implementing subds. (a), (b)(1), (b)(2), and (c)-(e) of § 14105.19 Welf. & Inst. Code, and §14166.245, subd. (a), Welf. & Inst. Code; including, without limitation, refraining from implementing the 10% rate cut, or any rate cut, in respect to Medi-Cal fee-for-service providers for dates of service on and after July 1, 2008, or at any time, pending final determination of this action.[26]

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[26] The preempted State statute in the ILC Plaintiffs' second case (No. 09-1158) was AB 1183.

AB 1183 was the successor to AB 5 when AB 5 sunset at the end of February 2009.

AB 1183 required the Director to deduct five percent from the Base Fee Schedule amount for Medi-Cal fee-for-service pharmacy providers (among other Medi-Cal services which were affected by AB 1183).

(End of quoted portion of ILC Plaintiffs' memorandum in support of preliminary injunction in the district court in 09-958.)

The Director's precise objection to this first ILC motion was his claim that no injunction could be issued under the Supremacy Clause, because the preempting federal law, Section 30A, created no "federal right" in the ILC plaintiffs to "enforce" Section 30A – which was claimed by the Director to be required by 42 U.S.C. § 1983 and the *Gonzaga* line of cases.[27]

The second objection of the Director to the first ILC motion for preliminary injunction case was his claim that there can be no cause of action because the ILC plaintiffs are unable to plead or show they have any "right" which was violated or threatened to be violated by the State's violation of the preempting federal law, Section 30A.[28]

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[27] *Gonzaga Univ. v. Doe*, 536 U.S. 273 (2002); *Blessing v. Freestone*, 520 U.S. 329 (1997); *Suter v. Artist M.*, 503 U.S. 347 (1992).

This objection is set forth in the Director's *Opposition* to the ILC plaintiffs' initial preliminary injunction motion, in June 2008. [Document 74 in Excerpts of Record in Appeals Case 08-56422, which is Document 35 in the docket of C.D. Cal, No. 2:08-cv-03315, in 09-958].

[28] The objection was that the ILC plaintiffs had no primary "right" to the performance of a corresponding "duty." Page 11 of the Director's *Opposition*. [This is Document 74 in Excerpts of Record in Appeals Case 08-56422, which is Document 35 in the docket of C.D. Cal. No. 2:08-cv-03315, in 09-958.]

The district court denied preliminary injunction; but was reversed by an appeals court order filed July 11, 2008, followed by an explanatory opinion filed September 17, 2008 (543 F.3d 1050).

The appeals court overruled the two objections of the Director, and remanded the case to the district court. The decision of the appeals court was precisely as set forth *en haec verba* below:

> The only issue before this court is . . . whether ILC may maintain a valid cause of action to enjoin implementation of AB 5 on the basis of federal preemption. (09-958 Pet. App. 67-68).
>
> . . .
>
> Under well-established law of the Supreme Court, this court, and the other circuits, a private party may bring suit under the Supremacy Clause to enjoin implementation of state legislation allegedly preempted by federal law.
>
> In this case, ILC alleges that the cuts violate the substantive provisions of the Medicaid Act, and are therefore unlawful. They do not seek to enforce any substantive "right" conferred by the statute. Instead, they argue that the cuts mandated by AB 5 are themselves unenforceable, because they exceed the scope of the State's discretion under the

> Act and violate federal standards. As AB 5 is causing injury to one or more of the ILC plaintiffs, and the other requirements of Article III standing were met, no more is required to allow this suit to go forward.

(End of quotation, at 09-958 Pet. App. 92-93).[29]

This basic decision of the Ninth Circuit, 543 F.3d at 1056-57, Pet. App. 68-69 cited:

- *Idaho v. Coeur d'Alene Tribe,* 521 U.S. 261, 281 ("An allegation of ongoing violation of federal law where the requested relief is prospective is ordinarily sufficient" to seek injunctive relief under *Ex parte Young,* 209 U.S. 123 (1908);
- *Lawrence County v. Lead-Deadwood Sch. Dist. No. 40-1,* 469 U.S. 256, 259 n.6 (1985) (failure to distribute federal funds as required by the federal law under which the funds were granted), describing *Shaw v. Delta Air Lines, Inc.,* 463 U.S. 85 (1983) as reaffirming the general rule that a plaintiff asserting preemption under 28 U.S.C. § 1331 has stated a federal claim for relief;
- *City of Burbank v. Lockheed Air Terminal, Inc.*, 411 U.S. 624 (1973): airport operator had no statutory right created by the preempting federal statute, but suffered economic or other adverse effect

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[29] 543 F.3d at 1065-66.

from city ordinance that limited flight landing hours, which conflicted with a federal law;

- *Ray v. Atlantic Richfield Co.*, 436 U.S. 151 (1978): tanker owner had no statutory right created by the preempting federal statute, but suffered economic or other adverse effect from a State law regulating minimum ship operations in State waters, which conflicted with a federal law;

- *Gade v. Nat'l Solid Wastes Mgmt. Assn.*, 505 U.S. 86 (1992): hazardous waste operators had no statutory right created by the preempting federal statute, but, suffered economic or other adverse effect from a State hazardous waste operator licensing law, which conflicted with a federal law;

- *P.G.&E. v. State Energy Res. Cons. & Dev. Comm.*, 461 U.S. 190 (1983): nuclear plant operator had no statutory right created by the preempting federal statute, but, suffered economic or other adverse effect from a State public safety and environment law, which conflicted with a federal law;

- *Fla. Lime & Avocado Growers, Inc. v. Paul*, 373 U.S. 132 (1963): avocado growers had no right created by the preempting federal statute, but, suffered economic or other adverse effect from a

State avocado marketing law, which conflicted with a federal law.

NOTE: This September 17, 2008 opinion became the law of the case, so as to be the decision upon which all the subsequent rulings in the ILC cases were based (whether or not the subsequent appeals court decisions under review in the ILC cases in 09-958 and 09-1158, mention this seminal September 17, 2008 opinion.

PART FOUR

THE DIRECTOR HAS IMPLICITLY CONCEDED THAT HIS FIRST MAJOR OBJECTION TO JURISDICTION AND CAUSE OF ACTION, HAS NO MERIT

The Director, by admitting in his merits brief (Dir. Brief 43) that a person may use the Supremacy Clause either as (1) a defense to a State suit against the person or (2) as the basis for a pre-emptive suit (mis-named as a "pre-enforcement suit" by the Director), to prevent being injured from prospective State implementation of a federally preempted State law, has conceded that both of his major premises, that:

- the ILC plaintiffs must have a *Gonzaga* "federal right" in order to file a Supremacy Clause pre-enforcement suit in the case at bar, and in any event,
- the ILC plaintiffs must have some "right" which was threatened to be

> violated by the State's violation of the preempting federal law, Section 30A,

are erroneous, so as to be no basis for the Court to overrule the affirmation by the appeals court of the preliminary injunctions of the district court in the ILC cases.

PART FIVE

ARGUMENT

THESE CASES ARE ABOUT INJURY

The ILC cases are about prevention of injury (i.e., adverse effect upon each of the ILC plaintiffs); and vindication of the federal interest in the supremacy of federal law; not, about "enforcement" of "rights"

Civil law is divided into two parts: the law of rights, and the law of injury.[30]

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[30] *See:*

– *Marbury v. Madison*, 5 U.S. 137, 163 (1803):

> [I]t is a settled and invariable principle in the laws of England that every right, when withheld, must have a remedy, and every injury its proper redress.

– *Western Pacific, Cal. R. v. Southern Pacific Co.*, 284 U.S. 47, 51-52:

> A person is a "party in interest":
>
> . . . if the bill discloses that some definite legal right possessed by the complainant is seriously threatened or that the unauthorized and therefore unlawful

(Continued on following page)

If one sues to enforce a right, then he must show he has the "right" he claims. Otherwise he is out of court. The ILC cases are not that case.

There is of course a large body of law dealing with the subject of "enforcement of rights," such as in the *Gonzaga/Freestone/Blessing* line of decisions.

Nevertheless there is a completely separate body of law which establishes that a person threatened with injury may, in the equity jurisdiction of the federal courts, obtain injunction to prevent being injured from on-going acts of a federal or a State officer which are contrary to, hence preempted (i.e., made void) by a federal law.

Below are just a few of the many decisions in which the cause of action has been that the plaintiff is threatened to be injured from federally preempted acts of a public officer.

> **First, the ILC plaintiffs list some of the many cases in which federal officers have been enjoined, or in which it was stated that injunction was available, to prevent injury from federal officers' acts contrary to supervening federal law:**

– *American School of Magnetic Healing v. McAnnulty*, 187 U.S. 94, 108 (1902):

> action of the defendant . . . may directly and adversely affect the complainant's welfare[.]

> The acts of all its officers must be justified by some law and in case an officer violates the law to the injury of an individual the courts generally have jurisdiction to grant relief. (187 U.S. at 108).

– *Abbott Laboratories v. Gardner,* 387 U.S. 136, 142-43 (1967):

> There is jurisdiction in equity for a suit to restrain the F.D.A., to prevent injury to a plaintiff, from implementing a regulation adopted contrary to the Federal Food, Drug, and Cosmetic Act of 1938. (387 U.S. at 142-43).

– The Department of Justice advised Congress in 1938:

> (A)ny citizen aggrieved by any order of the Secretary, who contends the order is invalid, may test the legality of the order by bringing an injunction suit against the Secretary, or the head of the Bureau, under the general equity powers of the court. 83 Cong. Rec. 7892 (1938). (*Abbott Laboratories,* 387 U.S. at 142-3).

– *Columbia Broadcasting System v. United States,* 316 U.S. 407, 422-423 (1942):

> Network broadcasting company may sue for injunction to prevent adverse effects on its economic welfare, from action of the FCC which are contrary to federal law.

– *Western Pacific,* 284 U.S. at 51-52:

> Railroad may sue for injunction, where unlawful action of a competitor adversely affected its economic welfare.

NOTE: *Abbott Laboratories* also held, 387 U.S. at 140, that judicial review of a final agency action **by an aggrieved person** will not be cut off unless there is persuasive reason to believe that such was the purpose of Congress.

Abbott Laboratories also reported the fact that during Congress' consideration of various bills to provide, in the Food, Drug, and Cosmetic Act, that consumers may sue, that it was recognized that "There is always an appropriate remedy in equity in cases where an administrative officer has exceeded his authority and there is no adequate remedy at law. . . . H.R. Report No. 2755, 74th Cong. 2d Sess. 8. (387 U.S. at 142)."

Second, the ILC plaintiffs list some of the many cases in which injunctions were issued, or in which it was stated that injunction was available, to prevent injury from State officers contrary to, hence preempted under the Supremacy Clause by, a federal statute:

– *Golden State Transit Co. v. Los Angeles,* 475 U.S. 608, 619-620 (1986): Held: The pleadings established a Supremacy Clause cause of action for preemptive injunction to prevent injury to a taxi company, from a city's violation of the NLRA.

- *Idaho v. Coeur d'Alene Tribe*, 521 U.S. at 281 (1997) (An allegation of ongoing violation of federal law where the requested relief is prospective is ordinarily sufficient to seek injunctive relief);
- *Lawrence County v. Lead-Deadwood Sch. Dist. No. 40-1*, 469 U.S. 256, 259 n.6 (1985);
- *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85 (1983);
- *City of Burbank v. Lockheed Air Terminal, Inc.*, 411 U.S. 624 (1973);
- *Ray v. Atlantic Richfield Co.*, 436 U.S. 151 (1978);
- *Gade v. Nat'l Solid Wastes Mgmt. Assn.*, 505 U.S. 86 (1992);
- *P.G.&E. v. State Energy Res. Cons. & Dev. Comm.*, 461 U.S. 190 (1983);
- *Fla. Lime & Avocado Growers, Inc. v. Paul*, 373 U.S. 132 (1963);
- The seven Supremacy Clause suits in respect to State violations of the Medicaid Act, listed prior in this brief.

Summary of this sub-point:

It is abundantly clear that to obtain an injunction to prevent injury – defined as an adverse effect upon the economic or other welfare of the Medicaid

beneficiaries and providers who are plaintiffs in the ILC cases, and, who are the patients, clients, and members of various of the ILC plaintiffs – the plaintiffs do not need to show any "right" created by the preempting federal statute, but, rather, need only plead or show that the State Legislature violated the preempting federal statute (Section 30A), and that implementing the preempted ten percent provider payment reduction of AB 5, and implementing the five percent provider payment reduction of AB 1183, would injure or threaten to injure the above-listed beneficiaries and providers.

***Bond v. United States*, 540 U.S. ___ (2011), resolves many issues in favor of the ILC plaintiffs in 09-958 and 09-1158.**

This is because it is implicit or a fair inference from *Bond* that:

First. The theory of the Director and the Government[31] that a plaintiff must plead a "right" in order to maintain Article III standing and a cause of action under the Supremacy Clause, is facially without merit.

Instead, as claimed by the ILC plaintiffs:

- An injury which is an adverse effect from a State or federal agency's action, as in the ILC cases, is sufficient for Article III standing and cause of action

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[31] Govt. Brief 13-16.

purposes if the injury meets Article III prudential requirements (*Bond, slip opinion* 3-8);

– An individual has a direct interest in objecting to State laws that upset the constitutional balance between the Union and the States when the enforcement of these State laws, as in the ILC cases, is contrary to supreme federal law, and causes injury to the individual that is concrete, particular, and redressable. (I.e., here, the ILC cases are a mirror situation of the *Bond* situation. See, *Bond, slip opinion* 10-11).

Second. The theory of the Director and the Government that because generally a plaintiff "cannot rest his claim on the legal rights or interests of others,"[32] that *ergo,* only the Government may assert a claim for the within State violations of Section 30A, is irrelevant in the ILC cases at bar: due to the fact that in the ILC cases the ILC plaintiffs are asserting their own injury from State government action taken in excess of the limits on a State that federalism defines. (See *Bond, slip opinion* 8).

I.e., here the ILC plaintiffs assert their own injuries (and the injuries of beneficiaries who are their

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[32] *Warth v. Seldin*, 422 U.S. 490, 499, 500 (1976); see also *Kowalski v. Tesmer*, 543 U.S. 125, 129-130 (2004).

patients, clients, or members), from State governmental action taken in excess of a limitation on State authority that federalism defines).

Third.

- (1) In *Bond* it was the United States who usurped a constitutional limit, whereas in the ILC cases it was a State who usurped a constitutional limit; and,

- (2) The federalism defense was raised by Bond as a defense in proceedings commenced against Bond; whereas, in the ILC cases, the ILC plaintiffs allege their Supremacy Clause defense in a preemptive suit in equity to prevent irreparable harm to themselves as Medicaid beneficiaries and providers, and to prevent harm to Medicaid beneficiaries who are the patients, clients, and members of various of the ILC plaintiffs.

Such preemptive suits to prevent irreparable injury are well established, under the equity jurisdiction afforded to the federal courts by Congress, and by 28 U.S.C. § 1331. *See, Idaho v. Coeur d'Alene Tribe of Idaho*, 521 U.S. 261, 281 (1997) (an allegation of an ongoing violation of federal law with request for prospective injunctive relief is ordinarily sufficient under *Ex parte Young*, 209 U.S. 123); John Harrison, *Ex parte Young*, 60 Stan. L. Rev. 989, 997-999 (2008).

Conclusion

For the above reasons, the ILC plaintiffs have Article III standing and a cause of action to obtain injunctive or declaratory relief to prevent being injured from the Director's preempted acts to implement the State laws, AB 5 and AB 1183, contrary to, hence preempted under the Supremacy Clause, by Section 30A.

The case made by the ILC plaintiffs below, is that the ILC plaintiffs did *not* sue to "enforce" any "federal right" or any "right" enacted by the preempting federal law, Section 30A; but sued to obtain injunctive relief to prevent being injured from the Director implementing two State laws (AB 5 and AB 1183) which were enacted contrary to, hence were preempted under the Supremacy Clause by, a federal law (Section 30A)

Thus, in the view of the ILC plaintiffs – and as expressly held by the Ninth Circuit in its September 17, 2008, opinion which became the law of the case in these ILC cases – the error of the Director and his amici is their insistence that for lack of any "right" enacted in their favor by Congress, that the battle is lost by the ILC plaintiffs.

However, as correctly pointed out by the appeals court in the September 17, 2008, opinion, the ILC plaintiffs did not sue in the ILC cases under the

"rights" branch of jurisprudence, but, rather, sued instead under the "injury" branch of jurisprudence.

Thus, the appeals court held in its September 17, 2008, decision, exactly this (09-958 Pet. App. 67-68):

> In this case, ILC alleges that the cuts violate the substantive provisions of the Medicaid Act, and are therefore unlawful. **They do not seek to enforce any substantive "right" conferred by the statute.** Instead, they argue that the cuts mandated by AB 5 **are themselves unenforceable**, because they exceed the scope of the State's discretion under the Act and violate federal standards. **As AB 5 is causing injury to one or more of the ILC plaintiffs, and the other requirements of Article III standing were met, no more is required to allow this suit to go forward.**

(Boldface emphasis supplied).

Hence the continued objection of the Director that the ILC plaintiffs have no "right," is simply irrelevant to the "injury" case made by the ILC plaintiffs.

Finally on this score, the ILC plaintiffs simply contend that, by filing their suit **under the "injury" branch of jurisprudence**, and alleging they were threatened with injury from on-going acts of a State officer contrary to the supreme law of the land (Section 30A), that they have satisfied the requirements

for standing and a Supremacy Clause cause of action, in the ILC cases.

These cases established that to state a cause of action for injunctive or declaratory relief to prevent injury by acts of a public officer, which are contrary to a federal law, there need not be any "injury" to a "right," but, only that some interest of the plaintiff be "adversely affected."

PART FIVE

THERE ARE AT LEAST THREE SUPREMACY CLAUSE CAUSES OF ACTION, ARISING FROM THE PLEADINGS AND MOTIONS OF THE ILC PLAINTIFFS

WHAT IS NOT AT ISSUE

There is no issue before the Court that the State laws in the ILC cases conflict with, hence are preempted by the Medicaid payment-setting statute, Social Security Act § 1902(a)(30)(A) – "Section 30A" – and that beneficiaries and providers would be injured by implementation of the preempted State laws in question.

This issue was resolved when the Court denied certiorari on exactly that question, in these ILC cases, and, granted certiorari only as to the First Question Presented.

THE CAUSES OF ACTION WHICH AROSE OUT OF THE FACTS IN EACH OF THE THREE ILC PLAINTIFFS' PRELIMINARY INJUNCTIONS

Several types of Supremacy Clause causes of action arose out of the ILC pleadings in the two complaints and three motions for preliminary injunctions in the ILC cases in Nos. 09-958 and 09-1158. These are described below.

FIRST CAUSE OF ACTION ARISING OUT OF THE FACTS OF THE ILC CASES IN 09-958 AND 09-1158

1. The facts pleaded and shown for each of three preliminary injunctions in the ILC cases, established a "pre-emptive" cause of action, respectively, under the Supremacy Clause for an injunction to prevent prospective injury

Such a pre-emptive type cause of action in equity is well recognized. See, Harrison, *Ex parte Young*, 60 Stanford L. Rev. 989 (2008); Kennedy, J., dissenting, in *Golden State,* 493 U.S. at 113, 115-118, and in *Dennis v. Higgins*, 498 U.S. 439, 457-458 (1991): a person has an immunity, which is a legal interest, from State action which violates a limit of the Constitution on State powers (*Golden State,* 493 U.S. at 113-114); which immunity provides the person the implicit right to obtain adjudication in litigation with

the State, that the State's action is a nullity (*Dennis*, 498 U.S. at 457).

Also, see, decisions which established the pre-emptive Supremacy Clause cause action (albeit in a Contracts Clause context) such as *Carter v. Greenhow*, 114 U.S. 317 (1895); *Board of Liquidation v. McComb*, 92 U.S. 531, 541 (1876); *Allen v. Baltimore & Ohio R. Co.*, 114 U.S. 311 (1885); and of course, *Ex parte Young*, 209 U.S. 123, 159-160 (1908).

The ILC plaintiffs submit that these authorities and case law established that:

(1) In a pre-emptive suit in equity to obtain protection against injury from preempted State action, the Supremacy Clause is self-executing, so as to automatically void any State law which is contrary to a federal law. This *inter alia* strips state officers of all authority and power to implement the preempted state law. *Ex parte Young*, 209 U.S. at 159-160.

(2) The officer's lack of authority and power gives rise to a correlative legal defense – which is a legal interest or an immunity – which can be used by the citizen – just as the ILC plaintiffs did use it in each of their three preliminary injunction motions in their cases at bar – as the basis of a cause of action in equity to obtain injunctive relief to restrain the officer from further preempted acts to implement the void, preempted state law.

NOTE: The ILC plaintiffs reason, and contend, that these characteristics dictate who may be the plaintiff in such a suit.

I.e., it is manifest that once the officer is stripped of all authority and power by the *in rem* preemptive effect of supreme federal law, to act, that the officer thereafter acts *sans law,* so as to be acting tortiously in the premises.

As such, all those who can or should be allowed to sue to restrain the officer from acting *sans law* in the premises, are those in the range of fire from the officer's lawless acts. Hence under this view, all persons adversely affected (i.e., injured) by the lawless acts of the officer, have a manifest right in equity for an injunction to restrain the officer from performing the acts which are injuring or threatening to injure the plaintiff.

It therefore is the case that in the ILC cases, both Medicaid beneficiaries and providers have a cause of action for injunction to prevent the Director from lawlessly acting, to injure them, because both are in the direct line of fire to be injured, were the Director to be permitted by the court to continue his lawless acts, contrary to federal law.

I.e., as noted by the appeals court, providers are injured simply because moneys otherwise payable to them, are withheld, under AB 5 and AB 1183.

And beneficiaries, *inter alia*, are injured or threatened to be injured, by the loss of access to

life-saving health care services, caused by providers not serving them, due to the reduced level of compensation for their professional services.

Conclusion:

For the above reasons, beneficiaries and providers have a cause of action for injunction to prevent injury from preempted prospective acts of the Director, contrary to supreme federal law, Section 30A: **irrespective of whether or not** they were intended beneficiaries of the preempting federal law, and **irrespective also** of whether or not, within a zone of reasonableness, Section 30A was enacted to protect them.

This result is compelled because the injury in a Supremacy Clause case is not the injury to some right which sounds in contract or the law of statute, but, rather, is an injury prospectively to be inflicted by the defendant, which sounds in tort law because in the premises, the officer is acting tortiously, *sans* any law to justify his lawless acts.

In any event, beneficiaries were clearly intended by Congress to be benefitted by the Medicaid Act and by Section 30A; and as such, had a cause of action for an order protecting them from injury caused by the Director's preempted acts.

Pennsylvania Pharm. Assn. v. Houstoun, 283 F.3d 531, 543-544 (3d Cir. 2002), Alito, J., held that

Medicaid beneficiaries "plainly satisfy the intended-to-benefit requirement," in respect to Section 30A.

The same reasons why beneficiaries are intended beneficiaries of Section 30A, also persuade that beneficiaries are well within the zone of interests to be protected by Section 30A (*Assn. of Data Proc. Service Org. v. Camp,* 397 U.S. 150, 153 (1970)).

Accordingly, it is manifest that under the principles of a Supremacy Clause pre-emptive suit, set forth above, beneficiaries clearly have Article III standing and a pre-emptive cause of action, in the ILC cases in 09-958 and 09-1158.

Injured providers and beneficiary organizations and member groups also have standing and a pre-emptive cause of action, in a representative capacity, for their patients, clients and members who are beneficiaries.

It follows that because beneficiaries have a pre-emptive cause of action in the ILC cases, so also do providers (here, the three pharmacy plaintiffs), and the Independent Living Center and the Gray Panthers groups, who are plaintiffs, have the same cause of action, to sue in a representative capacity, to advance the interests of the Medicaid beneficiaries who are their patients, clients, or members.

The decision of Hon. David Levi, former chief judge of the Eastern District of California, now the Dean of Duke Law School, in *Clayworth v. Bonta,* 295

F.Supp.2d 1110, 1117-20 (E.D. Cal. 2002), *reversed other grds.*, is definitive on this subject.

Summary

For the reasons given, each of the ILC plaintiffs had Article III standing, and a cause of action for a Supremacy Clause pre-emption suit, in equity, for injunction to prevent injury from on-going acts of the Director contrary to, hence preempted by, Section 30A.

SECOND CAUSE OF ACTION ARISING OUT OF THE FACTS IN THE ILC CASES IN 09-958 AND 09-1158

The facts pleaded and shown also established a cause of action in the ILC plaintiffs for injunctive relief, to enjoin on-going acts of the Director contrary to, hence preempted under the Supremacy Clause by, a federal law (Section 30A): – which cause of action is based on the principle that a plaintiff (1) showing Article III injury and (2) asserting preemption under the Supremacy Clause has stated a claim for relief.

Discussion

This specific Supremacy Clause cause of action in 09-958 was before the Court of Appeals and was **judicially approved** by the Court of Appeals in its

first decision in the ILC cases, filed September 17, 2008 (09-958 Pet. App. 58-93).[33]

The ILC plaintiffs here quote this September 17, 2008 appeals court decision verbatim, in its relevant part:

> Under well-established law of the Supreme Court, this court, and the other circuits, a private party may bring suit under the Supremacy Clause to enjoin implementation of state legislation allegedly preempted by federal law.
>
> In this case, ILC alleges that the cuts violate the substantive provisions of the Medicaid Act, and are therefore unlawful. They do not seek to enforce any substantive "right" conferred by the statute. Instead, they argue that the cuts mandated by AB 5 are themselves unenforceable, because they exceed the scope of the State's discretion under the Act and violate federal standards. As AB 5 is causing injury to one or more of the ILC plaintiffs, and the other requirements of Article III standing were met, no more is required to allow this suit to go forward.

(Quotation from 09-958 Pet. App. 67-68, 92-93).[34]

which decision cited the same cases which were prior cited by the ILC plaintiffs in Part Three of this brief:

---

[33] 543 F.3d 1050.

[34] 543 F.3d at 1055-1056.

– *Lawrence County v. Lead-Deadwood Sch. Dist. No. 40-1,* 469 U.S. at 359 n.6; *City of Burbank v. Lockheed Air Terminal, Inc.*, 411 U.S. 624; *Ray v. Atlantic Richfield Co.*, 436 U.S. 151; *Gade v. Nat'l Solid Wastes Mgmt. Assn.*, 505 U.S. 86; *P.G.&E. v. State Energy Res. Cons. & Dev. Comm.*, 461 U.S. 190; *Fla. Lime & Avocado Growers, Inc. v. Paul,* 373 U.S. 132 (1963); and *Green v. Monsour,* 474 U.S. 64, 68,

and in Part Five of this brief.

The ILC plaintiffs submit that these cases, and the appeals court decisions in 09-958 and 09-1158 were based on principles developed in case law in mid-last century, epitomized in cases such as *Abbott Laboratories v. Gardner, supra.*

These cases held, and their principle was, that persons aggrieved by administrative action, State or federal, had standing and a cause of action for injunctive relief to prevent harm from agency action in excess of and without authority of federal law.

The ILC plaintiffs suggest, also, that this standard Supremacy Clause cause of action is simply a manifestation and implementation – although not articulated as such – of the principle that the King must obey the law of the land, hence, may not injure a subject by acts which are contrary to the law of the land; (a rule in respect to which Magna Carta, clause 39 in the 1215 charter, the ILC plaintiffs submit, is but an example, and not a full statement of the rule).

Standing to sue

The ILC plaintiffs submit that they believe that their standing to sue should be based on the same criteria as the criteria for standing in the pre-emptive Supremacy Clause cause of action described prior in this brief, as in the First Cause of Action just prior discussed.

THIRD CAUSE OF ACTION THE FEDERALISM CAUSE OF ACTION ARISING OUT OF THE FACTS OF THE ILC CASES IN 09-958 AND 09-1158

A

The ILC plaintiffs as citizens have a right and recognizable interest – in their capacity as the intended and protected beneficiaries of federalism – to sue to protect themselves against injury from a State's violations of limits placed upon it by the power-allocating provisions of the Constitution – here, the Supremacy Clause.

This cause of action is implicit in the federalism system created by the division, allocation, and limits of and upon federal and state powers by the Constitution; hence shall be referred to in the ILC Brief as the "federalism cause of action."

Federalism is, simply, the allocation in the Constitution of powers to the national government, the reservation of all other powers to the states, and the provisions, which include the Supremacy Clause,

which allocate federal/state powers by limiting state powers, which created the boundaries between, and the spheres of power of, the national government and the states.

Central to federalism are the principles, which the Court has recognized since the beginning, both that a state, and a state law, must yield to a contrary federal law, whenever a state law conflicts with a federal law.

Also, the doctrine of federalism is based on the premise that the Constitution is not a compact between and for the benefit of sovereign states, but, rather, was stated to be and was adopted by the People, for *their* protection.

This system of federalism was adopted by the People for the protection of themselves, i.e., individuals. *See, New York v. United States,* 505 U.S. 144, 181 (1992), O'Connor, J.:

> "The Constitution does not protect the sovereignty of States for the benefit of the States or state governments as abstract political entities, or even for the benefit of the public officials governing the States. To the contrary, the Constitution divides authority between federal and state governments **for the protection of individuals**."

(Boldface emphasis supplied).

In this respect, the ILC submit that it is manifest also that federalism, with its division of powers and authority between the national and state government,

and its limitations on state powers when they conflict with federal law, was adopted by the People for the *inter alia* benefit, also, of citizens, i.e., individuals, as well as for their protection (which latter is noted by O'Connor, J., for the majority in *New York*).

de Toqueville is informative on this subject:

In *Democracy in America* (1839) he reported on and analysed the allocation of and the conflicts between federal and state powers. He reported that a chief concern of the Framers was "to arm the Federal government with sufficient power to enable to resist, within its sphere, the encroachments of the several states," but, at the same time, to avoid confrontation of the Union directly against a state, wherever possible.

He observed that to that end, that suits by private citizens were deemed to be the **means** by which state laws contrary to the interests of the Union could be attacked without having to bring in the Union as the litigant. Thus:

> The Americans hold that it is nearly impossible that a new law should not injure some private interests by its provisions. **These private interests are assumed** by American legislators **as the means of assailing such measures as may be prejudicial to the Union**, and it is to these [private] interests that the protection of the Supreme Court is extended.

(Boldface emphasis supplied).

Summary of this sub-point:

The federalism cause of action to protect individuals who were intended to be protected by the Constitution in respect to usurpation of limits of power imposed on states by provisions of the Constitution, including the Supremacy Clause, which allocated federal and state powers by limiting state powers, should be affirmed and validated by the Court in the ILC cases at bar, Nos. 09-958 and 09-1158.

B

Several factors suggest to the ILC plaintiffs that there is a federalism cause of action, or that such a cause of action may be recognized as such in cases such as the case at bar.

One factor is that the Court itself has signaled to the profession, and the public, as it were, that there may be such a cause of action, or a need for one, in order, by "giving life to the Supremacy Clause," to preserve in good working order the system of checks and balances, between the federal government and the States, and within the three branches of the federal government.

Thus, the Court in *Green v. Mansour* stated, in a case which had been mooted, that:

> Prospective relief of the sort awarded in *Ex parte Young* gives life to the Supremacy Clause. Remedies designed to end a continuing violation of federal law are necessary to

vindicate the federal interest in assuring the supremacy of federal law.

As pointed out by de Toqueville, it is unwieldy at best and risky at worst, for States and the federal government to only confront each other in courts, full-scale, *qua* Union, *qua* State.

In Social Security Act cases, in particular, Congress has apparently been unwilling to give the Secretary, its administrator of the various programs of the Act, all the powers to confront a State to enforce the Act, that even a corporate president has, to carry out a corporation's pledged purposes.

Thus the Secretary cannot (as the ILC plaintiffs read the Medicaid Act) even sue to obtain an injunction, when payment rates are too low, to require a State to conform its rate-setting practices, as one example, to the supreme federal law, Section 30A.

All that the Secretary can do is to withdraw all federal funds from a State, if the Secretary finds the State plan or its practices, contrary to the Medicaid Act. This is an atom bomb which no one, obviously, would ever want to be necessary to be used.

It is in this context then, that Medicaid beneficiaries and providers have a role – which, as noted by Alito, J., in the *Pennsylvania Pharm.* case – Congress indicated was a role they were expected by Congress to play. Thus, the House Committee report on 1981 amendments to Section 30A stated that:

> [I]n instances where the States or the Secretary fail to observe these statutory requirements, the courts would be expected to take appropriate remedial action. (*Id.*, 283 F.3d at 541).

Such a role to be played, of citizens affected by a given federal law or its administration being expected to come to court to prevent their injury therefrom, was reported by de Toqueville as being an expectation of the early legislatures of the Union.

Further, no matter how filled the tax coffers of the Union may be, they can never be enough by which to adequately fund a Secretary to police 50 States in their various administrations of the Act.

And since it is a given that federal funds are short in today's recession environment, the deployment of Medicaid beneficiaries and providers to guard, as it were, their own hen house by salutary suits, which complement and implement the supremacy of federal Medicaid law, is to the great advantage of not only the Federal fisc, but the ability of the Secretary, with limitations of funding, to adequately police the outskirts of the great Roman system known as the Medicaid Act.

Another factor which suggests the viability of a federalism cause of action, is the observation of Kennedy, J., in *Golden State,* 493 U.S. at 118, that the preemption immunity of the taxi company under the Supremacy Clause, (in the prior case, *Golden State*,

475 U.S. 608), "does not benefit the company as an individual."

This being so – that the Supremacy Clause acts *in rem* rather than *in personam* – it follows that the Supremacy Clause is an army with no soldiers to fulfill its function, unless individuals are allowed to defend themselves under the Supremacy Clause in response to violations of the Medicaid Act which injure them, – which vindicates the federal interest in assuring the supremacy of federal law, – for which such a need has been demonstrated, over the half-century life of the Act.

The result of all this is, that Medicaid beneficiaries and providers are the perfect match to the needs of the Secretary (to police transgressions of the States of the Medicaid Act's minimum requirements), and to the function of the Court, of giving life to the supremacy of federal law, in order to preserve the checks and balances of the federalism system.

Summary

The ILC plaintiffs therefore suggest and respectfully request the Court to address, recognize, and articulate in an appropriate order or decision, in the ILC cases in 09-958 and 09-1158, that there is an implied federalism cause of action, arising in favor of beneficiaries and providers in the Medicaid program, to be allowed (when they show the injury requisite for the "stake" requirement of Article III) to file challenges against State violations of the Medicaid Act as

preempted by the Supremacy Clause: which would vindicate the federal interest in assuring the supremacy of federal law.

The wording of Section 30A clearly prohibited the State from reducing provider payments for purely budgetary reason; and, there is no "vague or amorphous" or "broad and non-specific" language in Section 30A which authorizes the State to reduce Medicaid provider payments for purely budgetary reasons, or counsels against injured beneficiaries or providers defending themselves in court whenever the State cuts provider payments for purely budgetary reasons – in flat and deliberate violation of the quality and equal access clauses of Section 30A.

The fact is, which the ILC plaintiffs have chronicled in Part Two, that there have been at least eight lawsuits since the Act began, in which a State was enjoined by a court for enacting a Medicaid provider payment cut not in compliance with Section 30A, but in defiance of Section 30A: by enacting the payment cut for purely budgetary considerations.

Five of those injunctions, for flagrantly violating Section 30A by cutting provider payments for purely budgetary considerations, were against the Director and his predecessors.

(Three of these have occurred in the past three years.)

These payment cuts, for purely budgetary reasons, cannot possibly have been caused by any "ambiguous" or "vague and amorphous" wording of Section 30A, which the Director, joined by the United States, seek to tag Section 30A: even though this "ambiguous" claim was removed as a claim for review when the Court denied certiorari to the Director, on this issue (which was the central part of the Second Question Presented by Director).

To put it another way: There is nothing so vague and ambiguous about Section 30A, that prevented eight successive courts to eight times rule, that Section 30A clearly precludes a State from basing provider payment rate cuts, solely on budgetary considerations.

So to this degree – which is the only relevant degree to which this comes into these cases at all – Section 30A is very, very clear: so clear that the Director has been told five times over by the federal courts, that Medicaid provider payments cannot be cut, solely for budgetary reasons.

What is there not to understand about that?

In sum, Section 30A is a very clear statement that the State may not do what it did in these cases – namely, ignore the provisions of Section 30A, and reduce provider payments for purely budgetary reasons.

Conclusion

The purported issue of "ambiguity" is irrelevant in the case at bar because it is manifest that California always knew, from reading Section 30A and the injunctions served on it, that it is federally illegal to cut Medicaid payment rates again, solely for budgetary reasons (indeed, in the ILC cases, without even a pretense by the State, otherwise).

"Clear statement" is not at issue in the ILC cases, because the injunctions only speak prospectively.

I.e., it is the impression of the ILC plaintiffs that in past cases defendants were asked to pay damages or attorneys fees or do other future acts, for failure to be informed, **before these obligations were incurred**, that the State would have to undertake such burden when it accepted federal funding in a federal program.

That is not the case at bar. Here the Director is only being ordered to refrain from doing specified acts in the future. If the State wishes to avoid what it claims is a "cost," it can avoid the "cost" by not taking the federal money in the future.

THE DIRECTOR AND THE GOVERNMENT JOIN IN THEIR BRIEFS TO RAISE A DEFAULT DEFENSE WHICH IS WITHOUT MERIT

The new defense of the Director and Government is that there can be no implied Supremacy Clause cause of action, to prevent being injured from State violation of a supreme federal law, unless the State law in question regulates the conduct of the plaintiff in some way, and the "regulated person" sues to enjoin the preempted State regulatory law. (Dir. Brief 43-44; Govt. Brief 19-24).

This new proposed limitation on the scope of the Supremacy Clause, to only situations where a person is regulated by some State regulatory law, may be called, for convenience, a "pre-enforcement suit," to separate it from the broader, unlimited "preemption suit" which the Supremacy Clause authorizes and permits.

1. The all-inclusive wording of the Supremacy Clause repels the construction proposed by the Director and the Government: that only "pre-enforcement" causes of action exist under the Supremacy Clause

The words of the Supremacy Clause are clear: they include **all** preemption suits to prevent injury to a person from a State's violation of a supreme federal law, such as Section 30A, not, just "pre-enforcement" suits which the Director and the Government, in

vain, assert to the Court for the first time in its history, are the only suits which may possibly be filed under the Supremacy Clause, to prevent being injured from preempted State action.

There being no words of limitation or exception from this clear sentence, it follows that the Clause applies to all preemption suits in equity which seek a remedy in equity to prevent being injured from a State's violation of a federal law, **not, just to some** preemption suits – i.e., only to so-called "pre-enforcement suits" – (save and except of course, such Supremacy Clause suits in which the claims may not meet prudential standards, or, some insurmountable Eleventh Amendment problem is encountered).

Hence this defense of the Director and the Government is facially contradictory to the plain meaning of the words of the Supremacy Clause: hence should be rejected by the Court on this basis alone.

2. Supremacy Clause cases include many cases in which the preempted State law does not involve "regulation" of the plaintiff's conduct

The following are just a few of the many Supremacy Clause cases in which the preempted State law did not regulate the conduct of the plaintiff: *Golden State,* 475 U.S. 608 (1986), – in which summary judgment against a Supremacy Clause preemption action was overruled by the Court – the defendant's conduct was regulated by the NLRA, not,

the conduct of the plaintiff); *Hauenstein v. Lynham*, 100 U.S. 483 (1880); *Board of Liquidation v. McComb*, 92 U.S. 531, 540-541 (1876) (Contracts Clause); and *Baltimore & Ohio R. Co.*, 114 U.S. 311, 314-317 (1885) (Contracts Clause).

(A Contracts Clause violation claim necessarily involves the Supremacy Clause.)

The Constitution also prohibits a State from entering into any treaty, alliance, or confederation; grant Letters of Marque and Reprisal; coin money; emit Bills of Credit; ex post facto law, or grant any title or nobility.

But, none of these – all of which come under the Supremacy Clause if violated by a State – involve any State regulation of the conduct of a putative plaintiff.

In sum, the many Supremacy Clause cases or types of cases which do not fit the Government's default theory, destroy the theory.

3. Nothing in any of the cases or authority cited by the Director discuss or support this new proposition of the Director. Hence the proposal is entirely unsupported by the decisions which are cited for its support.

4. The proposed classification would facially violate the Due Process and Equal Protection rights of all persons so excluded, **including the ILC plaintiffs**, by depriving them of their right to sue to prevent being injured from State action which

violates the Constitution, a federal law, or a treaty of the United States.

THE CLAIM THAT THE MEDICAID ACT FORECLOSED SUPREMACY CLAUSE SUITS, HAS ALREADY BEEN REJECTED BY THE COURT SEVERAL TIMES

There is no evidence in the text or structure of the Medicaid Act that Congress intended to specifically foreclose any ability of beneficiaries or providers to sue to obtain a remedy under any provision of the Act. *See Blessing v. Freestone,* 520 U.S. 329, 346-348 (1997) (citing with approval holding in *Wilder v. Virginia Hospital Assn.*, 496 U.S. 498, 521 (1990), that federal government's power to reject state Medicaid plans or to withhold federal funding to States whose plans did not comply with federal law, accompanied by limited state grievance procedures for individuals was insufficient to preclude reliance on a cause of action for preemption.

Also, *see,* the seminal case of *Rosado, supra,* 397 U.S. at 420

> "We have considered and rejected the argument that a federal court is without power to review state welfare provisions or prohibit the use of federal funds by the States in view of the fact that Congress has lodged in the Department of HEW the power to cut off federal funds for noncompliance with statutory requirements. We are not reluctant to

assume Congress has closed the avenue of effective judicial review to those individuals most directly affected by the administration of its program. Cf. *Abbott Laboratories v. Gardner*, 387 U.S. 136 (1967); *Association of Data Processing Service Organizations v. Camp*, 397 U.S. 150 (1970); *Barlow v. Collins*, 397 U.S. 159 (1970). We adhere to *King v. Smith*, 3921 U.S. 309 (1968), which implicitly rejected the argument that the statutory provisions for HEW review of plans should be read to curtail judicial relief."

THE BRIEF OF THE UNITED STATES (PAGES 31-32), JOINED IN BY THE DIRECTOR, IS ESSENTIALLY A MOTION TO DISMISS THE PENDING ILC CASES IN 09-958, AND 09-1158, ON THE BASIS THAT SECTION 30A FORECLOSES THESE CLAIMS

THIS *DE FACTO* REQUEST SHOULD BE DENIED

The objection of the United States (Govt. Brief 31-32) is too late, and disregards that Congress, in Section 30A, did not foreclose access to the courts to Medicaid beneficiaries and providers to prevent injury from State action contrary to, hence preempted by, Section 30A.

First

As stated in the preceding Point, Congress did not foreclose access to the courts to beneficiaries and providers in respect to the provider-payment statute, Section 30A. Hence, it follows that Congress intended the courts to be open to them, not closed, as erroneously proposed by the United States.

Second

The Government's proposal furnishes no remedy to beneficiaries or providers.

The Medicaid Act affords no right to beneficiaries or providers to apply to or obtain any relief from the Secretary, when as has been repeatedly done during the past 47 years (see the cases cited by the ILC plaintiffs prior in this Brief), a State reduces provider payments solely for budgetary reasons, in knowing violation of Section 30A.

Please note that neither Medicaid nor the Secretary allow beneficiaries or providers any administrative remedies, such as FERPA allowed students in *Gonzaga,* such as: right to file a written complaint, which the agency then investigates; with the school required to respond in writing; with the agency then prescribing in writing, if a violation is found, what steps the institution must take to comply with FERPA, as to which *Gonzaga* held (536 U.S. at 289-290):

> "These administrative procedures squarely distinguish this case from *Wright* and *Wilder,* where an aggrieved individual lacked any federal review mechanism . . . "

Third

The United States is guilty of laches here.

It only objects after thousands of providers in California have been paid, and taken ownership rights in the ten percent or the five percent amounts which were required by the injunctions in these cases, to be paid to them.

So for the Court to in effect order the dismissal of the complaints of the ILC plaintiffs in these ILC cases in 09-958 and 09-1158, by reversing the appeals court decisions, not on the merits but **for the reasons stated by the United States** (Govt. Brief 31-32), would result tomorrow in the Director simply deducting an amount equal to the millions of $$$ which the Director paid under the relevant injunctions, from the warrants which are issued at regular intervals to providers in the Medicaid program in California.

This would in turn thrust the courts of California into another paroxysm of litigation between providers and the State over who owns those amounts which were paid out under the injunctions issued in these ILC cases: – when instead, the whole issue of who is entitled to those funds, could instead be effectively

determined in the within two lawsuits of the ILC plaintiffs, in 09-958 and 09-1158, on the merits.

Thus, since the federal courts first acquired and responsibly exercised jurisdiction on the issue of who should be paid these millions of $$$, it follows that (1) the Court should reject this late objection of the United States, and (2) **not** reverse the appeals court on **such non-merits** ground, but instead, (3) decide all issues relevant to these two cases, including who, ultimately, owns the funds which have been paid to providers as a result of the injunctions issued in 2008 and 2009 in 09-958 and 09-1158.

CONCLUSION AND PRAYER

For the reasons stated, the judgments below should be affirmed.

Dated: July 29, 2011

Respectfully submitted,

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FOR ARGUMENT Nos. 09-958, 09-1158, and 10-283

BRIEFS AND

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IN THE

Supreme Court of the United States

TOBY DOUGLAS, DIRECTOR, CALIFORNIA DEPARTMENT OF HEALTH SERVICES, *Petitioner*,
v.
INDEPENDENT LIVING CENTER OF SOUTHERN CALIFORNIA, INC., *et al.*, *Respondents*.

TOBY DOUGLAS, DIRECTOR, CALIFORNIA DEPARTMENT OF HEALTH SERVICES, *et al.*, *Petitioners*,
v.
CALIFORNIA PHARMACISTS ASSOCIATION, *et al.*, *Respondents*.

TOBY DOUGLAS, DIRECTOR, CALIFORNIA DEPARTMENT OF HEALTH SERVICES, *Petitioner*,
v.
SANTA ROSA MEMORIAL HOSPITAL, *et al.*, *Respondents*.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF OF RESPONDENTS SANTA ROSA MEMORIAL HOSPITAL, ET AL., NO. 10-283

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QUESTION PRESENTED

Whether there is an equitable right of action under the Constitution to enjoin state officials from implementing and enforcing state laws that violate Section 30(A) of the Federal Medicaid Act, 42 U.S.C. § 1396a(a)(30)(A).

CORPORATE DISCLOSURE STATEMENT

The corporate disclosure statement included in the brief in opposition of respondents Santa Rosa Memorial Hospital et al., No. 10-283, is incorporated herein by reference. No amendments to that statement are necessary.

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INTRODUCTION

Two centuries of this Court's precedents support a right of action to enjoin state legislation that is invalid under the Supremacy Clause. See, *e.g.*, Richard H. Fallon, Jr. et al., *Hart & Wechsler's The Federal Courts & The Federal System* 903 (5th ed. 2003) (*Hart & Wechsler*). The claims in this case—to enjoin the California Department of Health Care Services from enforcing reductions in Medicaid reimbursement rates that California enacted in violation of Section 30(A) of the Medicaid Act—fit comfortably within that line of authority. Neither petitioners nor their *amici* offer any persuasive reason why the availability of preemption claims arising under the Supremacy Clause should now be called into question.

They nevertheless argue that, even if these claims exist generally, they should be disallowed in this particular case because Section 30(A) does not confer a private right of enforcement. Petrs. Br. 15-16; U.S. Br. 10-11. These preemption claims do not, however, seek to "enforce" that provision, or to assert rights granted thereunder. Rather, they vindicate the structural, constitutional interest in the supremacy of national laws. That interest is enforceable in the federal judiciary as a matter of constitutional law, as this Court has "long ... recognized." *Corr. Servs. Corp.* v. *Malesko*, 534 U.S. 61, 74 (2001); see also *Bond* v. *United States*, 131 S. Ct. 2355, 2364-66 (2011). Statutory enforcement procedures may provide alternative means by which state violations of federal law can be addressed, but those procedures do not displace a right of action for equitable relief under the Supremacy Clause.

At bottom, it is properly the judiciary's role to decide when injunctive relief should be available to prevent or halt violations by state officials of the Constitution. Thus, the default rule is that traditional equitable power exists to enforce the Constitution's commands, particularly when Congress has not acted expressly and unequivocally to seek to limit the courts' inherent equitable authority.

The need for judicial intervention is particularly evident here. California enacted the rate reductions challenged in this case for the sole purpose of addressing budget concerns, without considering their impact on health care services as required by Section 30(A) of the Act. Those reductions have been squarely held to violate the Act, and this Court has declined to review that question. Indeed, the federal agency responsible for administering Medicaid, the Centers for Medicare and Medicaid Services (CMS), has itself found that these reductions violate the Act. U.S. Pet. Br. App. 1a-3a (No. 09-958).

Yet, absent the injunctions issued in this case, the State could have and would have imposed these unlawful reductions *for the past three years*.[1] CMS does not have the authority to compel compliance with the Act; rather, the only penalty it can impose for a violation is to withdraw the State's federal Medicaid funding. This draconian sanction is rarely sought, however, because it would lead to a result that is contrary to the primary purpose of the Medicaid Act—*i.e.*, to facilitate the provision of health care services to those otherwise unable to obtain them. And, even when sought, this sanction can be imposed only after a lengthy series of negotiations and hearings, a process that can (and often does) take years.

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[1] The first of these reductions took effect on July 1, 2008.

Permitting California to continue violating federal law with impunity would result in irreparable harm to those least able to bear the burden and would seriously undermine the constitutional structure in a fashion fundamentally inconsistent with two unbroken centuries of this Court's precedent. The claims in this case should be upheld, and the judgment below affirmed.

STATEMENT OF THE CASE

A. Federal Medicaid Program.

Enacted in 1965, the Medicaid Act establishes a cooperative federal-state program under which the federal government assists States to furnish medical assistance for poor, elderly, and disabled individuals. *Wilder* v. *Va. Hosp. Ass'n*, 496 U.S. 498, 502 (1990) (citing 42 U.S.C. § 1396). A State's participation is voluntary, but if it chooses to participate, it must comply with the Act's requirements and implementing regulations. *Id.* A participating State must establish and administer the Medicaid program through a "plan for medical assistance" that has been approved by the Secretary for Health and Human Services (HHS). *Id.* (quoting 42 U.S.C. § 1396a(a)).

A state plan must, among other things, ensure that payments to health care providers "are consistent with efficiency, economy, and quality of care" and "sufficient to enlist enough providers so that care and services are available ... to the general population in the geographic area." 42 U.S.C. § 1396a(a)(30)(A). This provision, Section 30(A) of the Act, requires that a State, before reducing reimbursement rates payable to health care providers, must first consider the effect on "the relevant statutory factors [of] efficiency, economy, quality of care, and access." Pet. App. 10-11 (No. 09-958). In particular, the State must make a

determination, based on "responsible cost studies ... that provide reliable data as a basis for its rate-setting," that the new rates "bear a reasonable relationship to efficient and economical hospitals' costs of providing quality services, unless the [State finds] some justification for rates that substantially deviate from such costs." *Id.*[2]

Material changes to prescribed reimbursement rates require an "amendment" to the State's Medicaid plan, and generally cannot be implemented until reviewed and approved by CMS (the operating department in HHS which oversees Medicaid). 42 C.F.R. §§ 430.12, 430.14, 430.15, 430.20, 447.256(c). An amendment submitted to CMS is deemed approved unless the agency takes formal action within 90 days, either by rejecting the amendment or requesting additional information. 42 U.S.C. § 1316(a); 42 C.F.R. § 430.16(a). A State whose plan is disapproved may seek reconsideration through administrative appeals and, ultimately, judicial review. 42 U.S.C. § 1316(a)(2)-(5), (b); 42 C.F.R. §§ 430.18, 430.38.

A participating State that administers its plan in violation of statutory requirements may be subject to funding-withdrawal proceedings under the Medicaid Act. 42 U.S.C. § 1396c; 42 C.F.R. § 430.66. The State must be afforded "reasonable notice and opportunity for hearing" in these proceedings, 42 U.S.C. § 1396c, to be conducted by a designated agency official, 42 C.F.R. § 430.66. Other interested parties may seek to intervene, *id.* § 430.76(b), but Medicaid providers and beneficiaries cannot initiate these proceedings, *id.* If the State is found to violate the Act, then (contingent on rights to administrative and judicial review) fed-

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[2] This interpretation of Section 30(A), applied by the courts below, *see, e.g.*, Pet. App. 10-11 (No. 09-958), is not at issue here.

eral Medicaid funding "shall" be withheld until the State demonstrates "that there will no longer be any such failure to comply." 42 U.S.C. § 1396c; see 42 C.F.R. § 430.35(d).

B. California Medi-Cal Program.

California is a participant in the federal Medicaid program. *E.g.*, Pet. App. 2-5 (No. 09-1158). It accepts funding under the Medicaid Act, and is bound by the Act's provisions, including Section 30(A). *Id.* The California implementation plan, as approved by CMS, designates the California Department of Health Care Services (DHCS) as the entity responsible for administering the State's Medicaid program, known as "Medi-Cal." *Id.*

In 2008 and 2009, the California legislature passed three bills reducing Medi-Cal reimbursement rates. The first, Assembly Bill 5 (AB 5), imposed an across-the-board 10% reduction on payments and reimbursement rates for hospitals, physicians, pharmacies, and other health care providers, to be effective July 1, 2008. *Id.* at 190-97 (enacted Feb. 16, 2008). The second, Assembly Bill 1183 (AB 1183), directed that the initial rate reductions would expire on February 28, 2009; thereafter, reimbursement rates would generally be reduced 1% from their pre-2008 levels, except that certain health facilities and pharmacies would be subject to a 5% reduction and hospitals not under contract with the State would be subject to the greater of a 10% reduction in allowable costs or 95% of the applicable average contract rate. *Id.* at 198-217 (enacted Sept. 30, 2008). Finally, Senate Bill 6 (SB 6) reduced the maximum contribution paid by Medi-Cal for wages and benefits relating to

in-home supportive services after July 1, 2009.[3] *Id.* at 218-27 (enacted Feb. 20, 2009). All of these reductions were enacted for the express purpose of addressing the State's budget deficit. See, *e.g.*, *id.* at 197.

Neither the California legislature nor DHCS studied the impact of these rate reductions on health care services prior to their enactment, as required by Section 30(A). Pet. App. 11-12 (No. 09-958); Pet. App. 17-29 (No. 09-1158); Pet. App. 2-3 (No. 10-283). The changes also were not submitted to CMS for approval prior to their initial implementation, as required by the Medicaid program. Pet. App. 11-12 (No. 09-958); Pet. App. 17-29 (No. 09-1158); Pet. App. 2-3 (No. 10-283). Not until September 2008, three months after AB 5 went into effect, did DHCS notify CMS of the changes. U.S. Pet. Br. App. 1a-3a (No. 09-958).

On December 24, 2008, CMS formally responded to DHCS's submission by requesting additional information concerning the State's justification for the rate reductions. *Id.* That request had the effect of postponing the review process, and CMS asked that DHCS provide the relevant information within 90 days. *Id.* DHCS, however, never replied. *Id.* Nearly two years later, on November 18, 2010, CMS notified DHCS that it was denying the amendments. *Id.* CMS explained that it could not approve the amendments because, among other things, "California has not demonstrated that it would meet the conditions set out in [Section 30(A)]." *Id.* The same day, DHCS requested reconsideration, *id.* at 2a, 5a-7a, thereby

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[3] The California legislature subsequently passed a bill that delays implementation of SB 6 until July 2012, and requires a court to validate the reduction prior to implementation. U.S. Br. 4.

triggering a formal administrative hearing, 42 C.F.R. § 430.18. To date, those proceedings remain pending.

C. Procedural Background.

The claims in this case, challenging AB 5, AB 1183, and SB 6 as inconsistent with Section 30(A) of the Medicaid Act, were brought in five separate lawsuits filed in (or removed to) federal courts in California on behalf of a diverse group of health care providers, Medicaid beneficiaries, and others adversely affected by the rate reductions. Pet. App. 1-38, 54-57 (No. 09-958); Pet. App. 53-54, 61, 95-96, 106-08, 111-12, 128-33 (No. 09-1158); Pet. App. 10-13 (No. 10-283).

In all of these actions, the district courts ultimately entered orders preliminarily enjoining DHCS from implementing the rate reductions. *E.g.*, Pet. App. 94-124 (No. 09-958). The courts held that the reductions were inconsistent with Section 30(A) of the Medicaid Act, and found that the plaintiffs would suffer irreparable harm if the reductions were allowed to go into effect. *E.g.*, *id.* These harms included not only revenue losses to health care providers—which might not be compensable, given the State's sovereign immunity—but also loss of services available to Medi-Cal beneficiaries, as providers would be forced to "turn away" new Medi-Cal patients and restrict services available to those individuals.[4] *Id.* at 108-21. These hardships, the courts found, outweighed the

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[4] In one of the actions, *California Pharmacists Association* v. *Maxwell-Jolly*, No. 09-722 (C.D. Cal.), the district court initially denied injunctive relief to certain plaintiffs on grounds of insufficient evidence of irreparable harm. Pet. App. 126-27 (No. 09-1158). The Ninth Circuit subsequently reversed that judgment as an abuse of discretion, because courts have recognized that the rate reductions would have precisely those effects. *Id.* at 38-39.

State's budgetary concerns. *Id.* at 121-22; see also Pet. App. 91-104, 133-50, 169-74 (No. 09-1158); Pet. App. 23 (No. 10-283).

In a series of appeals, the Ninth Circuit affirmed the preliminary injunction orders. On the threshold issue of whether plaintiffs had asserted a valid cause of action, it held that these claims were properly brought directly under the Supremacy Clause, without regard to whether they might also be brought under 42 U.S.C. § 1983 or through an implied statutory cause of action. *E.g.*, Pet. App. 58-93 (No. 09-958). "For more than a century, federal courts have entertained suits seeking to enjoin state officials from implementing state legislation allegedly preempted by federal law, and we see no reason to depart from the general rule in this case, or in this category of cases." *Id.* at 83. On the merits of the preemption claims, the court of appeals held that the rate reductions were inconsistent with Section 30(A) of the Medicaid Act, and therefore preempted under the Supremacy Clause, because the reductions had been enacted without the requisite "stud[y of] the[ir] impact ... on the statutory factors of efficiency, economy, quality, and access to care" or "consider[ation of] reliable cost studies when adjusting ... reimbursement rates." *Id.* at 11-12. It also affirmed the district courts' balancing of the equities, and their decision to grant preliminary injunctive relief, notwithstanding the State's assertion that the reductions were necessary in light of budget constraints. *Id.* at 12-13, 28-29.[5]

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[5] Although not all of the appeals were consolidated, they were all decided consistently and based on substantially the same reasoning. *See, e.g.*, Pet. App. 11-13, 58-93 (No. 09-958); Pet. App. 10-36, 38-40, 44-51, 54-57, 69-82 (No. 09-1158); Pet. App. 1-4 (No. 10-283).

Petitions for writ of certiorari were timely filed with respect to each of the appeals. Two questions were presented: (i) whether the Ninth Circuit properly had held, as a threshold matter, that the Supremacy Clause supports a constitutional preemption claim, and (ii) whether the Ninth Circuit properly had held, on the merits, that the California rate reductions contravene Section 30(A) of the Medicaid Act and are therefore preempted. This Court consolidated the petitions, and granted review only as to the first question. Thus, there is no question now that the state statutes violate Section 30(A) and are preempted; the only issue is whether a federal court has authority to issue injunctive relief to remedy California's established violation of the Supremacy Clause.

SUMMARY OF ARGUMENT

The claims in this case, to enjoin California from enforcing preempted state legislation, are supported by a long and unbroken line of precedent recognizing an equitable right of action under the Constitution to address ongoing constitutional violations. *E.g.*, *Malesko*, 534 U.S. at 74. The claims at issue here cannot be distinguished, as petitioners and the United States would have it, Petrs. Br. 15-17; U.S. Br. 10-11, merely because the federal statute on which they are based also provides an administrative process to withdraw federal funding in response to a statutory violation. That process offers the federal government a means to vindicate its own interests in ensuring a State's compliance with the Act, but they do not affect the rights of individuals adversely affected by unconstitutional state legislation to seek equitable relief in federal court.

1. It is "well-established" that the Constitution itself supports a right of action seeking prospective

equitable relief to address constitutional violations. *Hart & Wechsler*, *supra*, at 903. Scores of opinions from this Court have recognized such claims, and never has the Court so much as suggested that this constitutional right of action depends for its existence on congressional authorization. *Infra* Part I.B-C. Such a prerequisite would be flatly inconsistent with this Court's approach to other structural constitutional provisions that, like the Supremacy Clause, have always been understood to support a claim for prospective equitable relief without need for an authorizing statute. *E.g.*, *S.-Cent. Timber Dev., Inc.* v. *Wunnicke*, 467 U.S. 82, 87 (1984); see also *Bond*, 131 S. Ct. at 2364-66.

To reaffirm the longstanding recognition of this constitutional right of action would not be an "end run" (Petrs. Br. 35) around decisions like *Gonzaga University* v. *Doe*, 536 U.S. 273 (2002), and *Alexander* v. *Sandoval*, 532 U.S. 275 (2001), which require "rights-creating" language as a precondition to a statutory cause of action. *Infra* Part I.C.2. Claims seeking to enforce a *statute*, whether 42 U.S.C. § 1983 or any other, arise under the statute and thus are available only when authorized thereby. *E.g.*, *Golden State Transit Corp.* v. *City of Los Angeles*, 493 U.S. 103, 106 (1989). Claims seeking to enforce the *Constitution*, by contrast, arise as a necessary incident of the constitutional structure. *E.g.*, *S.-Cent. Timber*, 467 U.S. at 87; see also *Golden State*, 493 U.S. at 116-17 (Kennedy, J., dissenting); *Cannon* v. *Univ. of Chi.*, 441 U.S. 677, 733 n.3 (1979) (Powell, J., dissenting). Whatever role Congress may have in crafting adjudicatory mechanisms and remedies for constitutional claims, the Constitution itself empowers the judiciary to entertain suits alleging ongoing constitutional violations, including violations of the Supremacy

Clause, and to abate them when appropriate through prospective equitable relief.

2. This right of action is no less available when the preemption claim implicates a federal statute enacted under authority of the Spending Clause. *Infra* Part II.A. The only relevant issues in the preemption analysis are whether the federal statute is constitutionally applicable to the State and, if so, whether it conflicts with the challenged state law. *E.g.*, *Crosby* v. *Nat'l Foreign Trade Council*, 530 U.S. 363, 372 (2000). The constitutional basis for the federal statute has never been held relevant to this inquiry, or to the antecedent question of whether a cause of action is available. To the contrary, this Court has repeatedly upheld equitable relief on claims that alleged a conflict between state legislation and requirements of federal spending programs. See, *e.g.*, *Blum* v. *Bacon*, 457 U.S. 132, 145-46 (1982).

The possibility that federal funding might be withdrawn, or that the State might opt out of the program, does not render an individual preemption claim unnecessary or unavailable. *Infra* Part II.B. So long as the State remains a participant in the federal program, it is subject to the conditions imposed by federal law, and state legislation in contravention thereof is invalid under the Supremacy Clause, whether or not it is "possible" that the conflict might be avoided by a future change in circumstances. *PLIVA, Inc.* v. *Mensing*, 131 S. Ct. 2567, 2579 (2011). Regardless of what administrative remedies might be available to the federal government to allow it to vindicate its own interest in enforcing compliance with a federal program, individuals who are adversely affected by unconstitutional state legislation retain the right to seek prospective equitable relief in the federal courts.

3. A right of action under the Supremacy Clause is, in any event, fully consistent with the administrative process contemplated by the Medicaid Act. *Infra* Part III.A. The Act grants CMS authority to review state plans and, when appropriate, to reject those that do not comply with federal law. 42 U.S.C. §§ 1316(a)(1), 1396c. However, it does not define that process as exclusive, or otherwise suggest that individual preemption claims should be precluded. To the contrary, because administrative claims under the Act and preemption claims under the Supremacy Clause pursue complementary objectives—one to enforce compliance with federal law, and the other to enjoin state legislation in conflict with that law—both forms of action can and should be allowed.

The plaintiffs in this case are adversely affected by state laws that have been held unconstitutional and invalid under the Supremacy Clause. *Supra* pp. 7-9. Notwithstanding petitioners' late-raised (and waived) objection based on "prudential standing," Petrs. Br. 49-52, there is no reason that these parties should be denied a right of equitable relief to enjoin operation of those laws. *Infra* Part III.B. The judgment below should be affirmed.

ARGUMENT

I. THE SUPREMACY CLAUSE SUPPORTS A RIGHT OF ACTION TO ENJOIN PREEMPTED STATE LEGISLATION.

It has long been accepted, as the United States acknowledges, U.S. Br. 17-18, that the Supremacy Clause supports a claim for individuals to challenge preempted state legislation. *Hart & Wechsler*, *supra*, at 903; see also 13D Charles A. Wright et al., *Federal Practice and Procedure* § 3566, at 289-92 (3d ed. 2008). That principle, although disputed by petition-

ers, Petrs. Br. 33-45, accords with the original understanding of the Supremacy Clause, and two centuries of caselaw thereafter, as well as this Court's decisions in statutory rights cases such as *Gonzaga* and *Sandoval*.

A. A Preemption Claim Under The Supremacy Clause Is Consistent With The Original Understanding Of The Framers.

There is no evidence, notwithstanding petitioners' claims to the contrary, Petrs. Br 35-45, that the Framers of the Constitution would have thought that individuals adversely affected by state legislation invalid under the Supremacy Clause would be unable to seek equitable relief from the federal judiciary. To the contrary, the historical record suggests that they expected and intended such a right of action to be available.

1. The Framers' principal objective in crafting the Supremacy Clause was to establish an effective mechanism by which States could be compelled to adhere to federal law. Christopher R. Drahozal, *The Supremacy Clause* 6-7 (2004); see also, *e.g.*, 3 *The Records of the Federal Convention of 1787*, at 524-29 (Farrand ed. 1911) (Farrand). Although the Articles of Confederation had declared the principle of national supremacy and directed the States to "abide by" and "inviolably observe[ ]" national law, Art. of Confed., art. XIII, they provided no method to enforce that principle, with the result that several States had enacted legislation or exercised powers (such as negotiating treaties with foreign countries) in direct contravention of national law. Drahozal, *supra*, at 6-7; see also James Madison, *Vices of the Political System of the United States*, *in* 9 *The Papers of James Madison* 345, 348-58 (1975).

To remedy this defect, each plan offered at the Constitutional Convention would have given authority to one or more branches of the federal government to invalidate state legislation that was inconsistent with national policy—and, when necessary, to compel adherence. *E.g.*, 3 Farrand, *supra*, at 524-29; see also Drahozal, *supra*, at 6-7. For instance, one plan, offered by the delegates from New Jersey, would have allowed the executive to call forth the military against a recalcitrant State, 1 Farrand, *supra*, at 245; another, associated with the Virginia delegation, would have vested in Congress the power to "negative" state legislation deemed inconsistent with national law, *id.* at 21, 54, 164-65. The proposal ultimately adopted, embodied in the Supremacy Clause, shared the same purpose as other plans but delegated responsibility for enforcing the principle of national supremacy to the judiciary. *E.g.*, *id.* at 168, 313, 322; 2 Farrand, *supra*, at 28-29, 144, 169, 183, 389-91, 417, 603; see also 3 Farrand, *supra*, at 524-29; Drahozal, *supra*, at 20-23.

A private right of action to challenge preempted state legislation is necessary to allow the judiciary to satisfy this constitutional purpose. State legislation can be presented to federal courts only in the context of "cases" or "controversies," *e.g.*, 2 Farrand, *supra*, at 430, and the parties most able to bring these cases—in modern terms, those with "standing"—are those adversely affected by the state legislation. See, *e.g.*, David Sloss, *Constitutional Remedies for Statutory Violations*, 89 Iowa L. Rev. 355, 401-03 (2004). Without a right of action, there would be no mechanism by which unconstitutional state laws could be addressed, except in those cases where the State itself elected to bring an enforcement action in the courts, thereby implicating the Supremacy Clause as a defense.

It is inconceivable, given the Framers' recent experience under the Articles of Confederation, *e.g.*, 1 Farrand, *supra*, at 166-67, 316-17, 326, that they would have intended the enforcement of national supremacy to depend on voluntary action by the States. Nor would they likely have viewed the Supremacy Clause as nothing more than a "rule of decision," Petrs. Br. 35, directing States to follow national law—as had the Articles previously—but giving the federal courts no actual authority to invalidate unconstitutional state legislation. See, *e.g.*, James S. Liebman & William F. Ryan, *"Some Effectual Power": The Quantity and Quality of Decisionmaking Required of Article III Courts*, 98 Colum. L. Rev. 696, 762 (1998). The Framers understood and intended that the federal judiciary would be open to individuals injured by unconstitutional state legislation and empowered to issue orders declaring state legislation invalid and prospectively enjoining its enforcement. See, *e.g.*, Marsha S. Berzon, *Securing Fragile Foundations: Affirmative Constitutional Adjudication in Federal Courts*, 84 N.Y.U. L. Rev. 681, 706-07 (2009).[6]

2. This understanding is reflected at the Convention and ratification debates. Throughout those proceedings, the Supremacy Clause was consistently described as giving judges authority affirmatively to "set aside" and "declare void" (not merely "decline to

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[6] There is no support (even in the single source petitioners cite, Viet D. Dinh, *Reassessing the Law of Preemption*, 88 Geo. L.J. 2085 (2000)) for the suggestion that placement of the Supremacy Clause in Article VI, rather than Article I, somehow militates against recognition of a cause of action to enforce that Clause. Petrs. Br. 41; *cf.*, *e.g.*, *Corfield* v. *Coryell*, 6 F. Cas. 546 (C.C.E.D. Pa. 1823) (No. 3230) (Washington, J.) (addressing claim to enforce Privileges and Immunities Clause of Article IV); *infra* Part I.C.1 (citing cases addressing other constitutional claims).

enforce") state legislation that contravenes federal law. *E.g.*, 2 Farrand, *supra*, at 27-28, 391. Although constitutional remedies and rights of action were not a focus of the Convention, see Richard H. Fallon, Jr. & Daniel J. Meltzer, *New Law, Non-Retroactivity, and Constitutional Remedies*, 104 Harv. L. Rev. 1731, 1779 (1991), several delegates expressed the understanding that the federal judiciary should entertain claims by "any individual conceiving himself injured or oppressed by the partiality or injustice of a law of any particular State," 3 Farrand, *supra*, at 55-56 (Randolph), and that federal judges, when presented with an unconstitutional state law, would be able to grant prospective equitable relief in the form of a "supersedeas," *id.* at 524-29 (Madison).[7] During the ratification debates, both supporters and opponents of the Constitution assumed that the *federal* judiciary would be empowered "in the first instance" to decide the constitutionality of state laws—presumably in actions commenced by individuals, as it would have been unlikely for a State to bring an enforcement action in federal court. *Id.* at 286-87; see also *id.* at 205-07; 3 *The Debates in the Several State Conventions on the Adoption of the Constitution* 266 (Elliot ed., 2d ed. 1836).

This is consistent with the views set forth in *The Federalist Papers*. Petitioners heavily rely (Petrs. Br. 39-40) on a statement by Alexander Hamilton that the Supremacy Clause "only declares a truth, which flows immediately and necessarily from the institu-

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[7] The proposal by Edmund Randolph would have allowed the judiciary to invalidate not only state legislation found to be inconsistent with federal law but, further, any state laws deemed "contrary to the principles of equity and justice." 3 Farrand, *supra*, at 55-56; *see also* 1 Farrand, *supra*, at 97-98; 2 Farrand, *supra*, at 73-80.

tion of a federal government." *The Federalist No. 33* (Hamilton). But Hamilton did not state or even suggest that this "truth" was an unenforceable one. On the contrary, in light of the views expressed elsewhere by both Hamilton and James Madison, this statement suggests that they understood a right of action to challenge unconstitutional state statutes to be inherent in the constitutional structure, just as they understood the right of judicial review of federal legislation to be inherent in that same structure. See *The Federalist No. 44* (Madison); *The Federalist No. 80* (Hamilton).

This understanding fits squarely within contemporary legal practice. At the time of the Founding, colonial and English judicial practice permitted individuals to seek redress in equity for injuries resulting from an *ultra vires* act or void law. Thomas O. Main, *Traditional Equity and Contemporary Procedure*, 78 Wash. L. Rev. 429, 437-50 (2003).[8] For example, the English Board of Trade accepted and addressed petitions from colonists challenging local acts as inconsistent with English law. *E.g.*, Elmer Beecher Russell, *The Review of American Colonial Legislation by the King in Council* 50-52 (1915). The English Privy Council adjudicated appeals by colonists alleging that local provisions were "repugnant" to English law. *E.g.*, Arthur M. Schlesinger, *Colonial Appeals to the Privy Council*, 28 Pol. Sci. Q. 279, 287-88 (1913). Petitioners' *amicus* seeks to downplay these procedures as "fundamentally political and administrative in nature," Br. of Nat'l Gov. Ass'n 13, but does not explain

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[8] *See generally* Erwin C. Surrency, *Report on Court Procedures in the Colonies* (1700), *reprinted in* 9 *American Journal of Legal History* 167, 176 (1965); 1 Joseph Story, *Commentaries on Equity Jurisprudence as Administered in England and America* (14th ed. 1918).

why these analogous practices would not have informed the Framers' understanding of the role of the judiciary in reviewing local legislation. *E.g.*, 1 Farrand, *supra*, at 105, 138-40; 2 Farrand, *supra*, at 73-80 (referring to English practice in addressing judicial review).

B. This Court Has Consistently Recognized Preemption Claims Under The Supremacy Clause.

Consistent with this understanding, for nearly 200 years the Court has addressed claims seeking equitable relief against the operation of a preempted state law. *Hart & Wechsler*, *supra*, at 903. There are scores of such cases in this Court alone, just a sampling of which are set forth in the margin,[9] in addition to the unanimous recognition of such a cause of action by every single federal court of appeals to ad-

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[9] *See, e.g.*, *Rowe* v. *N.H. Motor Transp. Ass'n*, 552 U.S. 364 (2008); *Ark. Dep't of Health & Human Servs.* v. *Ahlborn*, 547 U.S. 268 (2006); *PhRMA* v. *Walsh*, 538 U.S. 644 (2003); *Gade* v. *Nat'l Solid Wastes Mgmt. Ass'n*, 505 U.S. 88 (1992); *Lawrence Cnty.* v. *Lead-Deadwood Sch. Dist. No. 40-1*, 469 U.S. 256 (1985); *Shaw* v. *Delta Airlines, Inc.*, 463 U.S. 85 (1983); *Pac. Gas & Elec. Co.* v. *State Energy Res. Conservation & Dev. Comm'n*, 461 U.S. 190 (1983); *Ray* v. *Atl. Richfield Co.*, 435 U.S. 151 (1978); *City of Burbank* v. *Lockheed Air Terminal, Inc.*, 411 U.S. 624 (1973); *Perez* v. *Campbell*, 402 U.S. 637 (1971); *Fla. Lime & Avocado Growers, Inc.* v. *Paul*, 373 U.S. 132 (1963); *Cloverleaf Butter Co.* v. *Patterson*, 315 U.S. 148 (1942); *Mintz* v. *Baldwin*, 289 U.S. 346 (1933); *Callam Cnty.* v. *United States*, 263 U.S. 341 (1923); *Cummings* v. *City of Chi.*, 188 U.S. 410 (1903); *R.R. Co.* v. *Peniston*, 85 U.S. (18 Wall.) 5 (1873); *Osborn* v. *Bank of the U.S.*, 22 U.S. (9 Wheat.) 738 (1824); *cf. Dobbins* v. *Comm'rs of Erie Cnty.*, 41 U.S. (16 Pet.) 435 (1842); *Weston* v. *City Council of Charleston*, 27 U.S. (2 Pet.) 449 (1829); *Soc'y for the Propogation of the Gospel* v. *Town of New Haven*, 21 U.S. (8 Wheat.) 464 (1823); *Houston* v. *Moore*, 18 U.S. (5 Wheat.) 1 (1820).

dress the question.[10] These cases were decided in each critical period in the evolution of enforcing constitutional claims against state actors—including, among others, the eras shortly after the Founding; before and after the Civil War and the enactment of § 1983; and throughout the Twentieth Century, both before and after this Court's decisions in cases like *Gonzaga* and *Sandoval*.

As early as 1824, in *Osborn* v. *Bank of the United States*, 22 U.S. (9 Wheat.) 738 (1824), the Court held that an entity could seek equitable relief against a state official acting under a state law preempted by the Supremacy Clause. *Id.* at 838. The Court expressly rejected the argument (similar to that offered by petitioners here, Petrs. Br. 35-36) that an individual who "perceives the approaching danger" of an invalid state law "can obtain no protection from the judicial department of the government." 22 U.S. (9 Wheat.) at 847. This Court instead held that it is the "province of [the judiciary], in such cases, to arrest the injury, and prevent the wrong." *Id.* at 845, 847.

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[10] *See, e.g.*, *Loyal Tire & Auto Ctr., Inc.* v. *Town of Woodbury*, 445 F.3d 136, 149 (2d Cir. 2006); *CSX Transp., Inc.* v. *Williams*, 406 F.3d 667, 672-74 (D.C. Cir. 2005) (per curiam); *Planned Parenthood of Houston & Se. Tex.* v. *Sanchez*, 403 F.3d 324, 330-35 (5th Cir. 2005); *Qwest Corp.* v. *City of Santa Fe*, 380 F.3d 1258, 1266 (10th Cir. 2004); *Verizon Md., Inc.* v. *Global NAPS, Inc.*, 377 F.3d 355, 368-69 (4th Cir. 2004); *Local Union No. 12004* v. *Massachusetts*, 377 F.3d 64, 75 (1st Cir. 2004); *BellSouth Telecomms., Inc.* v. *MCImetro Access Transmission Servs., Inc.*, 317 F.3d 1270, 1277-78 (11th Cir. 2003) (en banc); *Ill. Ass'n of Mortgage Brokers* v. *Office of Banks & Real Estate*, 308 F.3d 762, 765 (7th Cir. 2002); *GTE N., Inc.* v. *Strand*, 209 F.3d 909, 916 (6th Cir. 2000); *Elizabeth Blackwell Health Ctr. For Women* v. *Knoll*, 61 F.3d 170, 185 (3d Cir. 1995); *First Nat'l Bank of E. Ark.* v. *Taylor*, 907 F.2d 775, 776 n.3 (8th Cir. 1990).

Cases after *Osborn* continued to adjudicate claims for equitable relief directly under provisions of the Constitution, including the Supremacy Clause. See *supra* note 9. These include, among others, *Ex parte Young*, 209 U.S. 123 (1908), which upheld an individual's claim to enjoin state officials from enforcing an unconstitutional state law. *Id.* at 145-65. Certainly a key issue in *Young* was whether such a suit could be brought consistent with the Eleventh Amendment, Petrs. Br. 41, but what is significant here is the Court's acceptance of the fundamental, underlying right of action to enforce the Constitution. Indeed, the decision went out of its way to note the long history of such claims in the federal courts. 209 U.S. at 145-52. And, of course, the very purpose of *Young* was to preclude States from deterring potential plaintiffs from protecting their constitutional rights by threatening to penalize them for non-compliance with the State's unconstitutional requirement. See *id.* By holding that the private party could go to court to enforce the Constitution against state officials, this Court rejected the argument that constitutional provisions are enforceable only as a defense to an enforcement action.[11]

Through the last century and into this one, and despite changing views of the meaning and relevance of the phrase "cause of action," *e.g.*, *Davis* v. *Passman*, 442 U.S. 228, 236-44 (1979), this Court has repeatedly entertained affirmative claims to enjoin state officials from implementing preempted state legislation.

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[11] *See also Cherokee Nation* v. *Georgia*, 30 U.S. (5 Pet.) 1, 75-80 (1831) (Thompson, J., dissenting) (a claim for equitable relief against a preempted state law "presents a case for judicial consideration, arising under the laws of the United States," and "an injunction is a fit and proper writ to be issued, to prevent the further execution of such [state] law[ ]").

E.g., *Verizon Md. Inc.* v. *Pub. Serv. Comm'n*, 535 U.S. 635, 642-43 (2002); see also *Va. Office for Prot. & Advocacy* v. *Stewart*, 131 S. Ct. 1632, 1638-39 (2011).[12] In *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85 (1983), for example, the Court held that "[a] plaintiff who seeks injunctive relief from state regulation[ ] on the ground that such regulation is pre-empted [under] the Supremacy Clause ... presents a federal question which the federal courts have jurisdiction under 28 U.S.C. § 1331 to resolve." *Id.* at 96 n.14. These decisions "reaffirm[ ] the general rule" that equitable relief is available in the federal judiciary to enjoin state officers from implementing a state law preempted under the Supremacy Clause. *Lawrence Cnty.* v. *Lead-Deadwood Sch. Dist. No. 40-1*, 469 U.S. 256, 259 n.6 (1985).

To be sure, many of these decisions "assum[ed]" the existence of a claim under the Supremacy Clause, while focusing directly on questions of jurisdiction or the like. U.S. Br. 18-19; see, *e.g.*, *Swift & Co.* v. *Wickham*, 382 U.S. 111, 114-29 (1965). But, it cannot be disputed that these cases reflect an unbroken history of allowing individuals to "vindicate ... preemption claims by seeking declaratory and equitable relief in the federal district courts through their powers under federal jurisdictional statutes." *Golden State*, 493 U.S. at 119 (Kennedy, J., dissenting); cf. *Vt. Agency of Natural Res.* v. *United States ex rel. Stevens*, 529 U.S. 765, 773-78 (2000) (concluding that the "long tradition of *qui tam* actions," which the Court had "routinely entertained," was "well nigh

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[12] *See also supra* note 9; Robert Bruce Scott, *The Increased Control of State Activities by the Federal Courts*, 3 Am. Pol. Sci. Rev. 347 (1909); John E. Lockwood et al., *The Use of the Federal Injunction in Constitutional Litigation*, 43 Harv. L. Rev. 426 (1930).

conclusive" as to the justiciability of those claims). To hold otherwise, as petitioners request, Petrs. Br. 17-18, would cast doubt upon, if not directly overrule, the holdings of these cases and scores more.

Nor will reaffirmation that preemption claims may be brought directly under the Constitution result in the flood of new lawsuits petitioners and their *amici* prophesize. Petrs. Br. 26-33; Br. of States 12-15. This is for the simple reason that courts uniformly have recognized the availability of claims under the Supremacy Clause. See *supra* notes 9-10; U.S. Pet. Br. 16 (No. 09-958). Respondents merely ask this Court to confirm what is *already* "well-established." *Hart & Wechsler*, *supra*, at 903. Justiciability doctrines will, in any event, properly limit the scope of potential plaintiffs able to bring these challenges. See *infra* Part III.B.

C. Statutory Authorization Is Not A Prerequisite To A Preemption Claim Under the Supremacy Clause.

In none of the cases discussed above did this Court demand "rights-creating" or other authorizing statutory language as a prerequisite to a right of action under the Supremacy Clause. See *supra* note 9. Such a requirement would run counter to a large corpus of cases approving direct claims under other provisions of the Constitution and, contrary to petitioners' claims, Petrs. Br. 14-15, is not mandated by statutory rights cases such as *Gonzaga* and *Sandoval*.

1. Constitutional Claims For Equitable Relief Do Not Require Statutory Authorization.

Claims arising directly under provisions of the Constitution have "long been recognized" by this Court, without need for statutory authorization. *Malesko*,

534 U.S. at 74. Whatever role Congress has in defining and limiting the scope of remedies that are available in these actions, particularly with respect to monetary damages, a claim seeking purely equitable relief to abate an ongoing constitutional violation arises as a necessary incident of the Constitution.

1. This principle underlies *Bivens* v. *Six Unknown Named Agents of Federal Bureau of Narcotics*, 403 U.S. 388 (1971). That case, and those that followed from it, held that an individual whose constitutional rights are infringed by a federal official may bring an action in federal court for monetary damages. *Id.* at 392-97; see also *Carlson* v. *Green*, 446 U.S. 14, 19-21 (1980); *Davis*, 442 U.S. at 245-49. No statute authorized these actions, and in some cases Congress had provided alternative remedial schemes for the violations at issue. *E.g.*, *Green*, 446 U.S. at 19-21. Nevertheless, the Court reasoned that a damages remedy should be available to individuals injured by constitutional violations committed by federal officials, in part because 42 U.S.C. § 1983 provides a comparable remedy for violations committed by state officials. *Id.* at 21-22 & n.6, 24-25.

The availability of a *damages* remedy for constitutional claims has, of course, been circumscribed in the years since *Bivens*. *E.g.*, *Malesko*, 534 U.S. at 68. A damages remedy is retrospective in nature, intended to compensate the injured party and deter future violations, and is not strictly necessary to abate an ongoing constitutional violation. *Green*, 446 U.S. at 19-21. For that reason, the Court has generally limited it to circumstances in which the violation could not otherwise be addressed, and has held it unavailable when Congress provided a "meaningful" and "effective" alternative remedial scheme—even if the relief available under that scheme is not precisely the

same. *E.g.*, *Schweicker* v. *Chilicky*, 487 U.S. 412, 425 (1988); *Bush* v. *Lucas*, 462 U.S. 367, 385-86 (1983); see also *Hui* v. *Castaneda*, 130 S. Ct. 1845, 1852 (2010).

The Court has consistently reaffirmed, however—even when disallowing a damages claim under *Bivens*—that claims for equitable relief remain available. *Malesko*, 534 U.S. at 74; *United States* v. *Stanley*, 483 U.S. 669, 682-83 (1987); see also, *e.g.*, *Green*, 446 U.S. at 39 (Rehnquist, J., dissenting). Such claims exist as a matter of constitutional structure and necessity. See *Stanley*, 483 U.S. at 683 (claims for equitable relief "[do] not ask the Court to imply a new cause of action") (quoting *Chappell* v. *Wallace*, 462 U.S. 296, 305 n.2 (1983)). While Congress may by statute prescribe procedures for the adjudication and review of constitutional claims, see, *e.g.*, *Swift*, 382 U.S. at 114-15 (three-judge panels), and justiciability doctrines may independently restrict their availability in particular circumstances, see *infra* Part III.B; see also, *e.g.*, *Baker* v. *Carr*, 369 U.S. 186, 217 (1962), prospective equitable relief is "presumed availab[le] ... against threatened invasions of constitutional interests." *Bivens*, 403 U.S. at 404 (Harlan, J., concurring).

2. Cases outside the *Bivens* context likewise recognize "direct" constitutional claims seeking equitable relief for violations of the Constitution. *Malesko*, 534 U.S. at 74. Contrary to petitioners' argument, these claims have been approved not only for constitutional provisions that "confer ... substantive 'rights'" but also those—like the Supremacy Clause—that define the "structural relationship between the state and federal governments." Petrs. Br. 17-19.

In fact, there are numerous cases in which this Court has addressed claims arising directly under

"structural" provisions of the Constitution. These include, among others, claims under the Qualifications and Compact Clauses, *e.g.*, *U.S. Steel Corp.* v. *Multistate Tax Comm'n*, 434 U.S. 452, 458 (1978); *Powell* v. *McCormack*, 395 U.S. 486 (1969), as well as under more abstract constitutional principles such as separation of powers, *e.g.*, *Youngstown Sheet & Tube Co.* v. *Sawyer*, 343 U.S. 579, 635 (1952).[13] These cases confirm that "structural" provisions of the Constitution, no less than "rights-creating" ones, are enforceable through direct actions in federal courts.

This principle was strongly reaffirmed in a pair of this Court's recent decisions. In *Free Enterprise Fund* v. *Public Company Accounting Oversight Board*, 130 S. Ct. 3138 (2010), the Court expressly upheld "an implied private right of action directly under the Constitution to challenge governmental action under the Appointments Clause or separation-of-powers principles." *Id.* at 3151 n.2. It noted that a right to equitable relief for a constitutional violation "has long been recognized" and "[exists] as a general matter, without regard to the particular constitutional provisions at issue." *Id.* (quoting *Malesko*, 534 U.S. at 74).

Just last Term, in *Bond* v. *United States*, 131 S. Ct. 2355 (2011), this Court similarly held that "structural" constitutional provisions like the Tenth Amendment—which do not confer individual "rights" but ra-

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[13] *See also, e.g.*, *Hodel* v. *Irving*, 481 U.S. 704 (1987) (Takings Clause); *S.-Cent. Timber*, 467 U.S. 82 (Dormant Commerce Clause); *Allied Structural Steel Co.* v. *Spannaus*, 438 U.S. 234 (1978) (Contracts Clause); *Foster-Fountain Packing Co.* v. *Haydel*, 278 U.S. 1 (1928) (Dormant Commerce Clause); *Fallbrook Irrigation Dist.* v. *Bradley*, 164 U.S. 112 (1896) (Takings Clause); *Davis* v. *Gray*, 83 U.S. (16 Wall.) 203 (1873) (Contracts Clause).

ther define the relationship between federal and state governments—are nevertheless intended to "protect[ ] the liberty of ... persons" and for that reason may be asserted by an individual in a challenge to government action. *Id.* at 2364-65. In language particularly relevant here, the Court explained that, "[j]ust as it is appropriate for an individual, in a proper case, to invoke separation-of-powers or check-and-balances constraints, so too may a litigant, in a proper case, challenge a law as enacted in contravention of constitutional principles of federalism." *Id.*

These opinions reject the distinction that petitioners would draw between "rights-creating" and "structural" provisions of the Constitution. Petrs. Br. 17-19. On the contrary, they properly recognize that the Constitution's structural provisions protect individual liberties. *Bond*, 131 S. Ct. at 2363-64. They also explicitly recognize that negative restrictions on governmental power, like the Supremacy Clause, can support a challenge against government action and a claim for prospective equitable relief to abate an ongoing constitutional violation. *Free Enter.*, 130 S. Ct. at 3151 n.2. In arguing that the Supremacy Clause "should be treated differently than every other constitutional claim," petitioners—like the parties in *Free Enterprise* and *Bond*—"offer[ ] no reason and cite[ ] no authority why that might be so." *Id.*

2. The Analysis Applied In Statutory Right Of Action Cases, Including *Gonzaga* And *Sandoval*, Does Not Apply To Constitutional Claims.

"Rights-creating" language is not a prerequisite to claims asserted directly under the Constitution, including preemption claims under the Supremacy Clause. That requirement is applied to claims under 42 U.S.C. § 1983, see *Gonzaga*, 536 U.S. at 282, and

claims implied under federal statutes, see *Sandoval*, 532 U.S. at 286, but it has never been—and, contrary to petitioners' argument, Petrs. Br. 17-19, cannot be—applied to constitutional claims.

a. The remedy provided by § 1983 has, since its enactment, been understood to supplement and complement—but not to supplant—equitable relief already available through a claim under the Constitution itself. *E.g.*, *Section 1983 and Federalism*, 90 Harv. L. Rev. 1133, 1154, 1170 (1977); see also *Monroe* v. *Pape*, 365 U.S. 167, 173 (1961). Throughout the debates on the bill that would become § 1983, legislators explained that the statute would offer "*further* redress for violations ... of constitutional rights" and an "*additional*" remedy for individuals injured thereby. Cong. Globe, 42d Cong., 1st Sess. app. 315, 460 (1871) (emphasis added); see, *e.g.*, *id.* at 374, 429, 653. There is no evidence that Congress intended § 1983 to limit or disturb the traditional scope of preemption claims under the Supremacy Clause. To the contrary, supporters and opponents of the bill recognized the historical propriety of claims seeking prospective injunctive relief for constitutional violations, including actions to void unconstitutional state laws. *E.g.*, *id.* at app. 259 ("[T]he remedy [for a State's violation of the Constitution is that t]he Federal courts ... declare[] the statute null and void."); see also, *e.g.*, *id.* at app. 83, app. 221, app. 259, app. 315, 429.

This distinction finds further support in the fact that § 1983 was deemed necessary precisely because it addressed a different class of harms—injuries to federally conferred "rights"—than those remedied by a claim for injunctive relief under the "negative limitations" of the Constitution. *Id.* at app. 83. As one of the bill's sponsors explained:

> [Constitutional] prohibitions upon the political powers of the States are all of such nature that they can be ... enforced by the courts of the United States declaring void all State acts of encroachment on Federal powers. Thus, and thus sufficiently, has the United States "enforced" those provisions of the Constitution. But there are some that are not of this class. These are where the court secures the rights or the liabilities of persons within the States, as between such persons and the States.... [T]hese [are] the only provisions where it was deemed that legislation was required to enforce the[m] ....

Id. at app. 69; see also *id.* at app. 70. Prospective equitable relief is often not an effective remedy for a completed infringement of an individual's personal "rights," and for that reason a damages remedy was provided in § 1983, both to compensate the individual and deter future violations.[14] *E.g.*, *id.* at app. 50.

This rationale has been understood to justify limiting claims under § 1983 (and analogous damages claims under *Bivens*) to deprivations of federally conferred "rights," *Gonzaga*, 536 U.S. at 285-90, but it has no application to direct constitutional claims for prospective equitable relief. Whereas § 1983 by its

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[14] The three statements cited by petitioners' *amicus*, far from showing that the framers of § 1983 "believed that its equitable remedies were *new*," Br. of Nat'l Gov. Ass'n 29, establish only that they believed that equitable remedies, in addition to monetary damages, could and should be provided under § 1983 to protect against a violation of federally guaranteed "rights." *See* Cong. Globe, 42d Cong., 1st Sess. at 501 (noting that Congress has authority to enact § 1983, to provide "an original action in our Federal courts [for an] injunction [or] recovery of damages"); *see also id.* at 577 (referring to need to protect federally guaranteed "rights"); *id.* at 376 (same).

terms protects only "rights" guaranteed to individuals under federal law, *id.*, the Supremacy Clause declares broadly that "any Thing in the Constitution or Laws of any State" contrary to the "Constitution[ ] and the Laws of the United States" shall be invalid, without regard to whether the provisions at issue confer "rights." U.S. Const., art. VI, cl. 2; see *Golden State*, 493 U.S. at 117 (Kennedy, J., dissenting) ("Preemption [does not] concern[] ... the securing of rights, privileges, and immunities to individuals.").

It is certainly the case, as petitioners and the United States point out, that *some* preemption claims might also be brought under § 1983 because they implicate a particular "right" guaranteed by federal law. Petrs. Br. 34; U.S. Br. 26-27. But that additional, sometime avenue for relief is no reason to hold that § 1983 displaces constitutional preemption claims, any more than it displaces the myriad other constitutional claims that "ha[ve] long been recognized" to coexist with § 1983 (and *Bivens*) claims.[15] *Malesko*, 534 U.S. at 74. And, contrary to the United States' assertion, U.S. Br. 26-27, not all constitutional preemption claims could simply be restyled as § 1983 claims, or vice versa. See, *e.g.*, *Golden State*, 493 U.S. at 107-08; *Loyal Tire & Auto Ctr., Inc.* v. *Town of Woodbury*, 445 F.3d 136, 149 (2d Cir. 2006).[16] There

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[15] The statement in *Maine* v. *Thiboutot*, 448 U.S. 1 (1980), that when a statute provides no private right of enforcement § 1983 represents the "exclusive statutory cause of action," *id.* at 6, does not on its face suggest that § 1983 is the exclusive vehicle for *non-statutory* claims, *contra* U.S. Br. 28-29, and *Thiboutot* has never been read to support displacement of constitutional claims for equitable relief. *See supra* Part I.C.1.

[16] Indeed, neither of the § 1983 cases cited by the United States for this point—*Suter* v. *Artist M.*, 503 U.S. 347 (1992), and *Blessing* v. *Freestone*, 520 U.S. 329 (1997)—would be ame-

is no basis to restrict preemption claims under the Supremacy Clause to those based on a "rights-creating" statute.

b. Much the same can be said for petitioners' associated argument that constitutional preemption claims should be allowed only when authorized by the underlying federal statute, under the rationale of implied right of action cases like *Sandoval*. Petrs. Br. 20-26. Because the claims at issue in those cases were brought directly under *statutes*, the scope and availability of any cause of action depended on the statute itself. *E.g.*, *Sandoval*, 532 U.S. at 286. Claims under the Supremacy Clause, by contrast, are brought under the Constitution, and exist as a necessary incident of the Constitution's structure. See, *e.g.*, *Free Enter.*, 130 S. Ct. at 3151 n.2; see also *Malesko*, 534 U.S. at 74.

This argument exposes most clearly the flawed premise on which petitioners' position rests: that a preemption claim seeks to "enforce" a federal statute. *E.g.*, Petrs. Br. 20-22; U.S. Br. 30-31; see also Br. of States 2. Although a preemption claim commonly relies for its substance on the scope of a federal statute—to determine, for instance, whether the challenged state legislation impermissibly conflicts with federal law, see *Medtronic, Inc.* v. *Lohr*, 518 U.S. 470, 485-86 (1996)—it does not seek to "enforce" the sta-

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nable to such restyling. The claims in those cases did not seek to *invalidate* state laws under the Supremacy Clause and enjoin state officials from acting thereunder, as would a traditional preemption claim, but instead sought to *compel* state officials to take affirmative actions under federal statute. *Suter*, 503 U.S. at 352-53; *Blessing*, 520 U.S. at 337. In contrast, the claims in this case are classic preemption claims, in that they seek to declare the challenged legislation invalid and to prohibit petitioners from implementing it.

tute, as would a claim asserting an implied statutory right of action, *Sandoval*, 532 U.S. at 286. Rather, what is "enforced" in a preemption claim is the structural constitutional principle of supremacy, as declared in the Supremacy Clause. *E.g.*, *Douglas* v. *Seacoast Prods., Inc.*, 431 U.S. 265, 271-72 (1977) (preemption is "basically constitutional in nature, deriving its force from the operation of the Supremacy Clause"); see also Caleb Nelson, *Preemption*, 86 Va. L. Rev. 225, 234 (2000). The rule that compels preemption of contrary state legislation arises not from the federal statute but from the Constitution itself. See, *e.g.*, *PLIVA*, 131 S. Ct. at 2579-80 (Thomas, J.); cf. U.S. Br. 12 ("The question in these cases ... does not concern the States' substantive obligations under Section 1396a(a)(30)(A)."). It is the Constitution, therefore, that supports a right of action for these claims, without regard to whether the underlying statute might also provide one.

II. THE SUPREMACY CLAUSE SUPPORTS PREEMPTION CLAIMS BASED ON FEDERAL STATUTES ENACTED UNDER THE SPENDING CLAUSE.

Petitioners argue in the alternative that, even if preemption claims are generally available under the Supremacy Clause, they should be precluded when the underlying federal statute was enacted under authority of the Spending Clause. Petrs. Br. 46-49. That rule finds no support in this Court's decisions, and is at odds with the constitutional principle of supremacy.

A. A Preemption Claim Cannot Be Limited Based On The Constitutional Authority Under Which The Federal Statute Was Enacted.

The Supremacy Clause declares simply that "[t]his Constitution, and the Laws of the United States which shall be made in Pursuance thereof," shall be "the supreme Law of the Land." U.S. Const. art. VI, cl. 2. It does not distinguish between federal statutes based on which constitutional provision authorized Congress to act, and this distinction has never played a role in preemption analysis. See, *e.g.*, *Crosby*, 530 U.S. at 372; see also *PLIVA*, 131 S. Ct. at 2579-80 (Thomas, J.). Nor is this distinction relevant to whether a preemption claim is available. Such a claim seeks not to "enforce" the underlying statute, but to vindicate the federal structural interest in supremacy. See *Golden State*, 493 U.S. at 119 (Kennedy, J., dissenting); *Bond*, 131 S. Ct. at 2365; see also *supra* pp. 30-31. That constitutional interest is enforceable in the federal judiciary regardless of the particular authority under which Congress acted, or intended to act.

To be sure, "the purpose of Congress is the ultimate touchstone in every pre-emption case." *Wyeth* v. *Levine*, 129 S. Ct. 1187, 1194 (2009). But this inquiry into congressional intent, to determine "the scope of the statute's pre-empti[ve effect]," *Medtronic*, 518 U.S. at 485-86, goes to the merits of the preemption question, not to the antecedent question of whether a cause of action is available to enjoin the operation of preempted state law. See, *e.g.*, *Verizon Md.*, 535 U.S. at 642-43 (addressing merits of preemption claim without expressly resolving validity of the cause of action). This Court has never held that a state law may operate in contravention of a valid federal sta-

tute because of the particular power under which Congress proceeded. To the contrary, so long as the federal statute is constitutional and applicable, and is contrary to the state law, the state law is invalid, *Crosby*, 530 U.S. at 372, and a preemption cause of action is available.

Federal statutes enacted pursuant to Congress's Article I spending power are no exception. It is well-established that Congress "may fix the terms on which it shall disburse federal money to the States," *Pennhurst State Sch. & Hosp.* v. *Halderman*, 451 U.S. 1, 17 (1981), and once a State accepts federal money subject to such conditions, a state law contravening those conditions "runs afoul of the Supremacy Clause." *Lawrence Cnty.*, 469 U.S. at 270; see *Bacon*, 457 U.S. at 145-46 ("Because [the state rules] conflict with a valid federal regulation, they are invalid under the Supremacy Clause.").[17] The only difference between a federal statute enacted under the Spending Clause and one enacted under another constitutional provision, such as the Necessary and Proper Clause, is that a Spending Clause statute is constitutionally applicable to a State only insofar as the State satisfies the condition precedent of accepting federal funding.[18]

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[17] *See also Ahlborn*, 547 U.S. at 292; *Bennett* v. *Arkansas*, 485 U.S. 395, 397 (1988) (per curiam); *Townsend* v. *Swank*, 404 U.S. 282, 285 (1971); *King* v. *Smith*, 392 U.S. 309, 333 (1968).

[18] There is no merit to petitioners' novel suggestion that the principle of federal supremacy "does not belong" outside areas in which Congress exercises "exclusive ... authority." Petrs. Br. 48. When Congress acts pursuant to its constitutional authority, it displaces conflicting state law, regardless of whether the State would otherwise have authority to maintain that law. *See, e.g.*, *PLIVA*, 131 S. Ct. at 2581-82.

It is therefore unsurprising that, in *Pharmaceutical Research & Manufacturers of America* v. *Walsh*, 538 U.S. 644 (2003), seven Justices agreed that a plaintiff may bring a preemption claim to challenge a state law as invalid under the Medicaid Act. While these Justices differed over whether preemption had been established on the merits, they agreed on the threshold issue that the claim was available. *Id.* at 662 (plurality); *id.* at 671 (Breyer, J., concurring); *id.* at 687 (O'Connor, J., dissenting). The United States suggests that *PhRMA* "arose in a different context" because the plaintiffs there sought to invalidate a regulation affecting their "primary conduct," U.S. Br. 24, but it is immaterial under the Supremacy Clause whether state legislation regulates "conduct" or limits "benefits." If that legislation contravenes federal law, it is invalid. See, *e.g.*, *Bacon*, 457 U.S. at 145-46 (holding state law excluding individuals from benefits of federal-state program, in violation of program conditions, "invalid under the Supremacy Clause").

To the extent the United States proposes that constitutional preemption claims should be available only when the challenged state law would be subject to affirmative enforcement in an action brought by the State against the individual, U.S. Br. 19-24, such a rule would run counter to a number of this Court's decisions, see, *e.g.*, *Osborn*, 22 U.S. at 838, and the fundamental purpose of the Supremacy Clause, see *supra* Part I.A, in that it would allow States to violate federal law with impunity so long as they crafted their legislation to be essentially self-executing. Moreover, even if adopted, this rule would not preclude all of the claims asserted in this case. The reimbursement rate changes at issue here not only reduce the amounts paid by the State to providers, but also limit the amounts that providers may charge their

patients for services; a provider that charges patients in excess of those rates may be subject to liability in a claim brought by state officials under California law (as well as under federal law). See Cal. Welf. & Inst. Code § 14019.4(a) & (c); see also 42 U.S.C. § 1320a-7b(d). The reductions challenged in this case, thus, regulate the providers' "primary conduct," rendering them potentially subject to state enforcement actions if they do not comply. These parties would therefore be entitled, even under the United States' theory, to assert a preemption claim.

Tellingly, neither the United States nor petitioners cites any support for their suggested distinctions, and for good reason—there is none. No decision of this Court supports the proposition that judicial enforceability of a preemption claim depends on whether the displaced state law regulates "conduct" as opposed to limits "benefits," or on whether the federal law was enacted under authority of one constitutional provision rather than another.[19] In any event, if these considerations were relevant in preemption analysis, they would go to the *merits* of the preemption claim, not its threshold availability. Whether Congress framed a regulatory program as voluntary or cooperative, or only as an "assistance" plan, might influence the interpretation of particular statutory provisions and their preemptive scope. See, *e.g.*, *PhRMA*, 538 U.S. at 662. Those considerations would not, however, affect the existence of a preemption claim, and they offer no ground for denying its availability in one scenario rather than another.

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[19] Indeed, it is hard to see how such a rule would work in practice, as many federal statutes could be supported under multiple constitutional provisions. *Cf.*, *e.g.*, *Rumsfeld* v. *FAIR*, 547 U.S. 47, 58-59 (2006) (Solomon Amendment could be upheld under either Spending Clause or War Powers Clauses).

B. The Structure Of Spending Clause Legislation Does Not Preclude A Preemption Claim.

Nor can statutes enacted pursuant to Spending Clause authority be treated differently merely because they are "conditional," and based on a State's continued participation in the federal program. See Petrs. Br. 46-49; see also U.S. Br. 27-31.

1. Petitioners argue that a State's ability to stop accepting federal money—and thereby escape the reach of conditions imposed by a Spending Clause statute—precludes an action under the Supremacy Clause by parties injured as a result of the State's noncompliance. But, although this Court has analogized federal-state programs such as Medicaid to a "contract" between sovereigns, *e.g.*, *Pennhurst*, 451 U.S. at 17, that analogy has not been used to limit the federal statutes' preemptive reach, *e.g.*, *Bennett* v. *Ky. Dep't of Educ.*, 470 U.S. 656, 669 (1985). Indeed, the Court has specifically counseled against extending the analogy in that way. *Barnes* v. *Gorman*, 536 U.S. 181, 186 (2002) ("[W]e have been careful not to imply that *all* contract-law rules apply to Spending Clause legislation."). Petitioners' argument on this score fails for several reasons.

First, petitioners contend that, because States voluntarily accept the conditions imposed through federal spending legislation, no claim is available to enjoin violations of those conditions. Petrs. Br. 46-49. But, this Court has consistently maintained the propriety of injunctions that compel a State's compliance with federal funding conditions, so long as the State remains subject to those conditions. See, *e.g.*, *King*, 392 U.S. at 333; *Rosado* v. *Wyman*, 397 U.S. 397, 420-21 (1970); cf. *Pennhurst*, 451 U.S. at 30 n.23 (noting that the Court "would have little difficulty" upholding

an injunction that forced the State to choose between "rejecting federal funds ... or complying with" the conditions placed upon those funds). A State has no right to accept federal funding while at the same time claiming immunity from the federal obligations attached to those funds. *E.g.*, *King*, 392 U.S. at 333. If it finds those conditions unduly burdensome, it may discontinue accepting the funds to which the burden is attached. See *Rosado*, 397 U.S. at 420-21 (explaining that an injunction leaves a State with the "alternative choices of assuming the additional cost of [complying with the federal condition] or not using federal funds").

For this reason, state entities—like petitioners here—have less rather than more reason to complain about a cause of action seeking to hold them to compliance with the federal statute. If the State wishes to avoid the consequences of acting in a fashion inconsistent with federal law, including an action under the Supremacy Clause, it at all times holds the key to its own prison.

Second, there is no basis for allowing only "intended third-party beneficiaries" of the statute to bring a preemption claim when a State violates that statute. Petrs. Br. 34-51; see also U.S. Br. 27-28; Br. of APA Watch 8-14. Although contract law generally allows a third party to "enforce [a] contract" only when it was "made for his benefit," 9 John E. Murray, Jr., *Corbin on Contracts* § 44.1, at 45 (rev. ed. 2007), that principle—even if it were properly applied by analogy in this context—would affect only actions brought under the quasi-contractual statute itself, not preemption actions brought under the Supremacy Clause. As discussed earlier, *supra* pp. 30-31, a preemption action under the Supremacy Clause seeks not to "enforce" the statute, but to prevent injury

caused by operation of a constitutionally invalid state law.[20] In any event, there are affirmative reasons to conclude that Section 30(A), which requires a State to utilize "methods and procedures" that safeguard (among other things) the availability of care and services, was intended to benefit at least some of the diverse plaintiffs in this case. See *infra* Part III.A.

If anything, the analogy to contract law supports the availability of preemption claims based on Spending Clause enactments. Contracting parties operate against a backdrop of default legal rules that govern the interpretation of their agreement. See, *e.g.*, Restatement (Second) of Contracts § 5(2) & cmt. b (1981). When a State accepts federal funding and agrees to be bound by certain conditions, the terms of the relevant "contract" include the constitutional provisions that structure relations between the federal and state governments—including the Supremacy Clause. And, because the Supremacy Clause has for two centuries been treated as providing a cause of action for individuals aggrieved by a preempted state law, *supra* Part I.B, a State that accepts funding under a federal statutory program should understand that a cause of action under the Supremacy Clause will be available to enjoin state action that violates the federal law.

2. A preemption claim under the Supremacy Clause is no less available when, as here, the State's noncompliance with federal law might also trigger a

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[20] For this reason, the decision in *Astra USA, Inc.* v. *Santa Clara County*, 131 S. Ct. 1342 (2011), on which both petitioners and the United States rely, Petrs. Br. 34-35; U.S. Br. 25-26, is inapposite. There, the plaintiffs sought to enforce the terms of the statute itself, as embodied in a form contract through which the statute was implemented. 131 S. Ct. at 1345. Here, the claims at issue arise under the Constitution.

withdrawal of funding by the federal government. Whatever authority Congress might have to displace particular constitutional remedies for certain constitutional violations, this Court never has held that an administrative funding-withdrawal mechanism, without more, is sufficient to demonstrate congressional intent to displace a right of action under the Constitution. To the contrary, the Court repeatedly has held that the possibility of federal funding withdrawal does not preclude judicial relief for parties injured by non-complying States. See, *e.g.*, *Rosado*, 397 U.S. at 420 ("We have considered and rejected the argument that a federal court is without power to ... prohibit the use of federal funds by the States in view of the fact that Congress has [delegated] the power to cut off federal funds for noncompliance with statutory requirements."); see also *Ark. Dep't of Health & Human Servs.* v. *Ahlborn*, 547 U.S. 268, 272 (2006) (state law "contravened federal [Medicaid provision] and was therefore unenforceable").[21]

These cases confirm that the possibility of funding withdrawal does not substitute for, and cannot displace, a constitutional preemption claim. Whereas a preemption claim seeks to declare a state law void, the withdrawal of funding effectively accomplishes

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[21] These decisions are consistent with this Court's approach to claims under § 1983, which this Court consistently has held not to be displaced by funding-withdrawal provisions. *See, e.g.*, *Wilder*, 496 U.S. at 522; *Wright* v. *Roanoke Redevelopment & Hous. Auth.*, 479 U.S. 418, 428 (1987). Similarly, the possibility of administrative funding withdrawal, without more, is insufficient to override evidence that Congress intended to provide a private right of action under a statute. *See Cannon*, 441 U.S. at 704-06. In this latter category of cases, of course, the relevant inquiry is not whether Congress intended to preclude an action otherwise available, but whether it intended to create a right of action in the first instance. *See, e.g.*, *Sandoval*, 532 U.S. at 286.

the opposite, eliminating the applicability of the federal regulatory program. See *Rosado*, 397 U.S. at 420 ("[The State] is, of course, in no way prohibited from using only *state* funds according to whatever plan it chooses, providing it violates no provision of the Constitution."). And, although the *threat* of funding withdrawal may be a useful tool in inducing compliance, its actual implementation ultimately harms, rather than helps, those who would bring a preemption cause of action under the Supremacy Clause—the individuals who depend upon or otherwise benefit from federal regulatory programs. Cf. *Cannon*, 441 U.S. at 704-06 (explaining that funding withdrawal is a "severe" tool that "often may not provide an appropriate means" of addressing "isolated violation[s]").

This case clearly illustrates the inadequacy of funding withdrawal as an alternative to preemption claims. Without some mechanism for parties who are injured by the violation of federal law to vindicate federal supremacy, States would be able to enact and enforce unconstitutional reductions in prescribed Medicaid reimbursement rates unless and until a federal administrative body undertook the process necessary to effectuate a withdrawal of federal funds. *Supra* pp. 4-5. That process is often lengthy; here, for example, the administrative process regarding the disapproval of California's *2008* plan amendment is still underway. *Supra* pp. 6-7. Were funding withdrawal the only available option, affected individuals would be left unable to prevent an ongoing constitutional violation in the meantime, including to prevent irreparable harm, and would face the perverse result that the sole "relief" they could hope to achieve—the termination of federal funding—might well leave them even worse off.

More fundamentally, petitioners' argument that the *possibility* of funding withdrawal might displace a preemption claim reflects a critical misunderstanding of the Supremacy Clause. That Clause renders state law that is inconsistent with any currently applicable federal statute invalid and void, whether or not that inconsistency might at some later date be resolved. Just last Term, this Court recognized precisely this point, refusing to uphold a preempted state law based on "conjectures" regarding "hypothetical federal action[s]" that might later validate that law. *PLIVA*, 131 S. Ct. at 2579 & n.6. Likewise here, although there is always a possibility that a withdrawal of federal funding may render the Medicaid Act inapplicable—just as it is hypothetically possible that California may withdraw from the federal program and terminate the Medi-Cal system—those imagined possibilities cannot serve to validate state laws that currently conflict with a federal statute. Nor can they preclude a right of action to challenge those laws under the Supremacy Clause.

III. CONGRESS DID NOT BAR RESPONDENTS' CLAIMS FOR INJUNCTIVE RELIEF AND PRUDENTIAL STANDING PROVIDES NO BASIS FOR DENYING RESPONDENTS ACCESS TO THE FEDERAL COURTS.

In their final alternative argument, petitioners and the United States assert that these particular claims should be disallowed, either because Section 30(A) of the Medicaid Act is inconsistent with a private right of action, U.S. Br. 24-33, or because respondents do not have prudential standing, Petrs. Br. 49-52. Neither point is valid.

A. Section 30(A) Does Not Bar These Claims.

It is axiomatic that claims for equitable relief against ongoing constitutional violations arise under the Constitution itself, not any statute. *Supra* Part I.C.1. The substantive preemption analysis may rest on underlying federal statutes, but the right of action exists separate and apart from those provisions.

That point alone is enough to defeat the argument that Section 30(A) bars these claims. Petrs. Br. 23-32; U.S. Br. 24-33. Because a constitutional preemption claim does not depend on the federal statute at issue, the scope and purpose of Section 30(A) are irrelevant in assessing the availability of these claims.[22] However, even assuming the contrary—*i.e.*, that a preemption claim might be displaced in certain circumstances by the underlying federal statute—nothing in Section 30(A), or the Medicaid Act more generally, has that effect.

1. It is clear, as an initial matter, that Congress did not explicitly preclude these claims. The Medicaid Act contains no express limitation on the rights of injured parties to seek injunctive relief to remedy constitutional violations, based on Section 30(A) or otherwise, and neither petitioners nor their *amici* point to any such language.

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[22] This is, again, not to say that Congress could not prescribe certain adjudicatory and remedial procedures for constitutional claims. *See supra* p. 23-24. Here, however, petitioners and the United States are arguing not that Congress has defined particular procedures for seeking relief under the Supremacy Clause but, rather, that Congress has precluded that relief entirely, through implicit repeal by operation of Section 30(A). Petrs. Br. 23-32; U.S. Br. 24-33.

If any inference is to be drawn from the statute itself, then, it is that Congress did not intend to disallow private rights of action that would otherwise be available to private plaintiffs. See, *e.g.*, *Rosado*, 397 U.S. at 420 (addressing preemption claim based on Spending Clause statute); *Ahlborn*, 547 U.S. at 272 (same); see also *Green*, 446 U.S. at 20-22. Indeed, this Court so held in *Wilder*, concluding that a cause of action under 42 U.S.C. § 1983 to enforce "rights" created by certain provisions of the Medicaid Act was available because, among other reasons, Congress had not expressly prohibited such claims in the Act. 496 U.S. at 520-21.[23] The same reasoning confirms the availability of the constitutional claims asserted in this case.

2. Notwithstanding the lack of express statutory support for their position, petitioners and their *amici* contend that these claims should be disallowed because they would be "in tension" with the Medicaid Act's regulatory scheme. Petrs. Br. 26. That scheme, they assert, suggests an intent to "centraliz[e] enforcement authority in HHS[ ] and protect[ ] the States from private lawsuits." *Id.*; see also U.S. Br. 25, 30. Nothing in the statute, however, supports this inference or indicates that a preemption claim would interfere with the administrative process.

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[23] The legislative report cited by petitioners, relating to the 1997 repeal of the so-called "Boren Amendment," Petrs. Br. 32-33, indicates that Section 13(A) of the Act should not "be interpreted as establishing a cause of action for hospitals and nursing facilities relative to the adequacy of the rates they receive," H.R. Rep. No. 105-149, at 590-91 (1997), but it does not address constitutional preemption claims generally, or those based on Section 30(A) specifically, and provides no basis to hold such claims displaced by the Act.

That process is notably limited in scope. CMS is afforded only the opportunity to review state plans that are formally submitted for its consideration. 42 U.S.C. § 1316(a). Nowhere does the statute address whether or how CMS or others may seek an order directing a State to comply with statutory or regulatory requirements; nor does it set forth any procedures by which CMS could review constitutional violations that may exist independent of, or in connection with, statutory and regulatory violations. And at no point does the Act indicate that those administrative proceedings constitute the exclusive means by which statutory violations may be addressed.

Indeed, in reviewing this very scheme in *Wilder*, the Court concluded that it "*cannot* be considered sufficiently comprehensive to demonstrate a congressional intent to withdraw the private remedy of § 1983." 496 U.S. at 522 (emphasis added). The Medicaid Act, the Court explained, gave the agency only "limited oversight" over States and was therefore "insufficient" to support the conclusion that Congress intended to foreclose other remedies. *Id.* Petitioners offer no basis to conclude—and there is none—that the same enforcement scheme that was insufficient to displace a statutory claim is, by contrast, sufficient to displace one under the Constitution.

Tellingly, neither petitioners nor their *amici* read the statute as precluding *all* private remedies. For example, petitioners acknowledge that private parties may bring actions against state agencies under § 1983 to enforce other state plan conditions of the Medicaid Act, Petrs. Br. 46-47 n.17, even though those conditions appear in the same general section and are subject to the same administrative enforce-

ment scheme as Section 30(A).[24] That petitioners agree that some private claims are available under the Act, and may be pursued without obstructing the administrative enforcement process, fatally undermines their argument that the claims in this case would somehow "interfere with" or "disrupt" (Petrs. Br. 28) that process.[25]

Nor does any nebulous goal of "national uniformity, consistency, and predictability" in the administration of the Medicaid program, *id.* at 27, compel rejection of these claims. It is clear, as *Wilder* itself recognized, that Congress did not intend to vest "exclusive" authority in HHS to enforce the Act, U.S. Br. 32, but instead anticipated that the federal courts would have a role in the interpretation and enforcement of the Act's provisions. 496 U.S. at 522. Concerns over conflicting judicial interpretations are properly addressed not through *ad hoc* limitations on private rights of action, of the type petitioners and the United States seek, but through standard avenues of judicial and administrative review. If the United States believes that the courts below or others have misconstrued or misapplied Section 30(A), it may ask CMS

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[24] For example, the same mechanism of plan review and funding withdrawal applies whether a State's noncompliance involves a system-wide failure to provide required process when setting rates, 42 U.S.C. § 1396a(a)(30)(A), or a system-wide failure to provide required process when reviewing denials of benefits. *id.* § 1396a(a)(3). Yet, according to petitioners, the latter provision could support a preemption claim while the former would impermissibly conflict with the administrative review scheme. Petrs. Br. 46-47 & n.17.

[25] Indeed, the Act explicitly preserves such claims, stating that a "provision is not to be deemed unenforceable because of its inclusion in a section of this chapter requiring a State plan or specifying the required contents of a State plan." 42 U.S.C. § 1320a-10.

to issue a formal interpretation of that provision, which then (if otherwise proper and reasonable) would presumably be binding on federal courts. See *Nat'l Cable & Telecomms. Ass'n* v. *Brand X Internet Servs.*, 545 U.S. 967, 982-83 (2005). And, to the extent petitioners complain they cannot "predict" what Section 30(A) requires, Petrs. Br. 16, the answer is that they may seek agency review *before* implementing scheduled changes in Medicaid rates—something the State here did not do. *Supra* pp. 6-7. Preemption claims addressing Section 30(A) will not in any way impede the ability of the agency to construe and implement the statute, or of States to operate thereunder.

3. This case vividly illustrates why the enforcement scheme provided by Section 30(A) cannot substitute for a constitutional preemption claim.

States are required to submit plan amendments for approval by CMS whenever there are "[m]aterial changes in State law," 42 C.F.R. § 430.12(c)(1), and CMS must approve an amendment *before* a State may change its reimbursement rates. *E.g.*, *Exeter Mem'l Hosp. Ass'n* v. *Belshe*, 145 F.3d 1106, 1108 (9th Cir. 1998). In this case, however, the State did not submit amendments regarding the changes required by AB 5 and AB 1183 until approximately three months *after* each set of changes went into effect. *Supra* pp. 6-7. As a result, plaintiffs here began to suffer injury from the changes to the State's reimbursement rates before CMS could even begin its review. See 42 C.F.R. § 430.16(a). With no administrative enforcement action possible, and retrospective relief unavailable, a private judicial action seeking injunctive relief is the only means by which plaintiffs like these could avoid irreparable injury as a result of a state law that is void under the Supremacy Clause.

Moreover, the potential for injury is far greater than the several months' lag between implementation of the plan changes and submission of the plan amendments to CMS. In this case, the State ignored CMS's request for additional information on its plan amendment regarding AB 5; yet, CMS did not act to disapprove the amendment until more than *two years* after it was initially submitted. *Supra* pp. 6-7. That decision is now subject to reconsideration proceedings requested by the State, which are still ongoing—more than half a year later. Thus, if petitioners were correct that no claim under the Supremacy Clause was available, there *still* would be nothing to prevent the State from implementing the rate reductions. States seeking to achieve cost savings through acts of noncompliance could do so for years without the possibility of injunction or practical enforcement.

All of this simply confirms what is already required as a matter of constitutional law: a claim seeking injunctive relief against state laws in violation of the Medicaid Act, including Section 30(A), is available to these plaintiffs. That right of action exists separate and apart from the underlying statute and, in any event, is fully consistent with the structure and purpose of Section 30(A) and the Medicaid Act.

B. The Prudential Standing Doctrine Does Not Bar These Claims.

In the final pages of their brief, and for the first time before this Court, petitioners suggest that these claims might be dismissed based on justiciability concerns relating to the prudential standing doctrine. Petrs. Br. 49-52. This argument is raised far too late to be considered now, and in any event is without merit.

It is true as a general matter that justiciability doctrines apply to and limit claims under the Supremacy Clause, just as they limit other causes of action brought in the federal courts. *E.g.*, *Bond*, 131 S. Ct. at 2364-66. Political questions will be dismissed as non-justiciable, *e.g.*, *Baker*, 369 U.S. at 217, and plaintiffs suffering no injury-in-fact from the challenged government action will lack standing under Article III, *e.g.*, *Raines* v. *Byrd*, 521 U.S. 811, 821-26 (1997). It is these doctrines—and not the artificial and unprecedented limitations on Supremacy Clause claims proposed by petitioners—that properly ensure that courts are not "transform[ed] ... into all-purpose regulatory enforcers of Spending Clause enactments." Petrs. Br. 14-15; see also Br. of States 12-15.

One of these doctrines—and the only one that petitioners mention, Petrs. Br. 49-52—is prudential standing. That doctrine, petitioners now argue, bars these claims because they purportedly (i) rest on the rights of a third party (*i.e.*, the federal government), (ii) are not within the "zone of interests" protected by the Medicaid Act, and (iii) constitute "generalized grievances." *Id.*

These arguments have, as an initial matter, been waived. Petitioners acknowledge that they did not raise them in all of the appeals below, and that the Ninth Circuit did not "overtly" address them. *Id.* at 50 & n.19. In fact, the only opinion by the court of appeals to mention "prudential standing" specifically states that the issue has been waived. Pet. App. 90 n.17 (No. 09-958) ("By failing to articulate any argument challenging [plaintiffs'] prudential standing, the Director has waived that argument."); cf. *MedImmune, Inc.* v. *Genentech, Inc.*, 549 U.S. 118, 138 (2007) (Court will not consider issues that were not pressed or passed upon below). Not surprisingly,

therefore, prudential standing was raised in none of petitions for certiorari as a ground for challenging the judgment below. There is no reason for the Court to address this late-raised objection for the first time now. See *Gen. Talking Pictures Corp.* v. *W. Elec. Co.*, 304 U.S. 175, 179 (1938) ("One having obtained a writ of certiorari to review specified questions is not entitled here to obtain decision on any other issue.").[26]

The prudential standing arguments offered by petitioners also lack merit. These claims do not rest on the rights of the federal government, as petitioners allege, Petrs. Br. 51, but are based on individual injuries suffered by these plaintiffs. *Supra* pp. 7-9; see also *Bond*, 131 S. Ct. 2364-66 (claims that secondarily advance interests of federal government do not implicate the prohibition on third-party claims). Nor is this suit outside the relevant "zone of interests": these plaintiffs are seeking to enforce not the Medicaid Act, but the Supremacy Clause, *supra* pp. 30-31, and in any event there is no doubt that they will be injured as a direct result of the State's violation of the Act, *supra* pp. 7-9. And, although those injuries may be "widely shared" among Medicaid providers and beneficiaries, the losses alleged are concrete and real,

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[26] There would be no basis for petitioners to argue that the question of whether a right of action exists under the Supremacy Clause "fairly include[s]" the separate question of whether these particular claims are barred by the prudential standing doctrine. Sup. Ct. R. 14.1(a) ("Only the questions set out in the petition, or fairly included therein, will be considered by the Court."). Nor could that issue be deemed a "necessary predicate" to resolution of this case, *e.g.*, *Caspari* v. *Bohlen*, 510 U.S. 383, 389-90 (1994), given that prudential standing is a discretionary doctrine and, even if properly raised and applicable, would not necessarily preclude a court from adjudicating the claims, *see, e.g.*, *Elk Grove Unified Sch. Dist.* v. *Newdow*, 542 U.S. 1, 12 (2004).

supra pp. 7-9, and are not remotely an abstract "generalized grievance."

These plaintiffs will suffer irreparable harm from the rate reductions challenged in this case. See *supra* pp. 7-9. They are entitled to seek relief from those reductions through a claim arising under the Supremacy Clause.

CONCLUSION

For all of the foregoing reasons, the judgment of the court of appeals should be affirmed.

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July 29, 2011

RECORD AND BRIEFS

Nos. 09-958, 09-1158, and 10-283

SEP 1 - 2011

In the
Supreme Court of the United States

TOBY DOUGLAS, Director of the Department of Health Care Services, State of California,

v.

INDEPENDENT LIVING CENTER OF SOUTHERN CALIFORNIA, INC., A Nonprofit Corporation, et al.

TOBY DOUGLAS, Director of the Department of Health Care Services, State of California, et al.,

v.

CALIFORNIA PHARMACISTS ASSOCIATION, et al.

TOBY DOUGLAS, Director of the Department of Health Care Services, State of California,

v.

SANTA ROSA MEMORIAL HOSPITAL, et al.

On Writs of Certiorari to the United States Court of Appeals for the Ninth Circuit

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INTRODUCTION

Respondents offer an unbounded and ahistorical theory of private enforcement of federal statutes. They suggest that Article III standing is all that a private party must establish to judicially enforce a federal law against a state. So long as there is an "injury," there is a lawsuit; congressional intent to permit private enforcement is irrelevant. *Santa Rosa* Resp. Br. 42 ("[T]he scope and purpose of Section 30(A) are irrelevant in assessing the availability of these claims."); *Dominguez* Resp. Br. 29-37 (arguing that Congress's intent not to create any privately enforceable rights is irrelevant). Were Respondents' theory adopted, private litigation over federal statutes would entirely eclipse the administrative enforcement mechanisms created by Congress, as anyone affected by enforcement of a federal statute could sue if they disagreed with how a state was implementing it.

I. This Court's precedents authorize private actions to enforce federal statutes only where Congress intended to permit such private actions – and thereby prevent exactly this sort of wholesale reallocation of legislative and executive branch power and responsibility to the judiciary. *See, e.g.*, *Gonzaga Univ. v. Doe*, 536 U.S. 273 (2002); *Alexander v. Sandoval*, 532 U.S. 275 (2001); *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1 (1981); *Davis v. Passman*, 442 U.S. 228 (1979). As Respondents have irrevocably conceded, under these precedents, Congress did not confer any privately enforceable rights in enacting 42 U.S.C. § 1396a(a)(30)(A). Respondents suggest that

this Court should create a private remedy anyway, based on a distorted description of the record, the Ninth Circuit's holdings, and the enforcement powers of the United States Department of Health and Human Services (HHS). HHS's enforcement options are more nuanced and flexible than Respondents suggest, and any arguments that they are inadequate should be made to Congress rather than the courts.

II. Neither the Supremacy Clause nor the federal courts' equity jurisdiction supplies the means to circumvent congressional intent.

A. Largely abandoning the Supremacy Clause as the vehicle for their claims, Respondents shift focus to the courts' equity jurisdiction, which they contend supplies a private cause of action to anyone who claims injury based on a "conflict" between federal and state law. However, equity was never as expansive as Respondents suggest, but provided relief through established forms of proceeding. *See Rees v. City of Watertown*, 86 U.S. (19 Wall.) 107, 122 (1874); Philip Hamburger, *Law and Judicial Duty* 338-39 (2008). Respondents' claims do not fit within the bill to restrain proceedings at law at issue in *Ex parte Young*, 209 U.S. 123 (1908); the bill to enjoin trespass upon personal property at issue in *Osborn v. Bank of the U.S.*, 22 U.S. (9 Wheat.) 738 (1824); or any of the other remedies-based causes of action in the federal equity cases they cite. Moreover, the availability of private equitable relief for purported violations of federal statutes has long been circumscribed by such concerns as separation-of-powers and respect for state

sovereignty. *See, e.g.*, *Sandoval*, 532 U.S. 275; *Blessing v. Freestone*, 520 U.S. 329 (1997); *Seminole Tribe of Fla. v. Florida*, 517 U.S. 44 (1996); *Pennhurst*, 451 U.S. 1.

B. Even if a standalone preemption claim could be asserted in other contexts, Respondents could not use such a vehicle to enforce § 30(A) for two reasons. First, Respondents' cases lack the "repugnancy" element that is so critical to the Supremacy Clause. The allegation that the State has failed to satisfy a statutory funding condition sounds more in contract than it does in the Constitution. Second, Respondents cannot rely on preemption to frustrate congressional intent to vest enforcement of § 30(A) in an administrative agency. Respondents plumb the legislative history of § 30(A) and the Medicaid Act in an attempt to find evidence of contrary intent that does not exist. The legislative history on which Respondents rely invariably concerns *other* provisions of the Medicaid Act that *have* been held to confer privately enforceable rights.

C. Several different strands of prudential standing also bar Respondents' claims. The State has preserved these arguments (although not every strand was preserved in all of the underlying seven appeals). Respondent providers' arguments that they fall within § 30(A)'s zone of interest is premised on the wrong legal standard, and they cannot satisfy the correct one. *Clarke v. Sec. Indus. Ass'n*, 479 U.S. 388, 400 n.16 (1987).

ARGUMENT

I. RESPONDENTS CANNOT JUDICIALLY ENFORCE § 30(A) BECAUSE CONGRESS HAS NOT PROVIDED FOR A PRIVATE RIGHT OF ACTION

Respondents lack a private cause of action to enforce § 30(A) because Congress did not create one. Respondents concede that, unlike other provisions of the Medicaid Act, § 30(A) does not create any individualized "rights," whether to a specific level of access, a specific level of provider payments, or anything else. *See Sanchez v. Johnson*, 416 F.3d 1051 (9th Cir. 2005). To the contrary, the text and structure of § 30(A), and the relevant legislative history, confirm congressional intent that this federal statute be enforced administratively by HHS rather than through private suits. *Id.* at 1059-62; Pet. Br. 29-33. Because Congress "controls the availability of remedies for violations of statutes," and because Congress has not provided a private remedy here, Respondents lack a cause of action to enforce § 30(A). *See Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 508 n.9 (1990); *see also Gonzaga Univ. v. Doe*, 536 U.S. 273, 280 (2002); *Alexander v. Sandoval*, 532 U.S. 275, 286 (2001). Accordingly, the Ninth Circuit's judgments in the underlying appeals must be reversed.

1. There is nothing "talismanic" (*Cal. Pharm.* Resp. Br. 15) about the application of this Court's precedents here, rooted as they are in separation-of-powers principles. Specifically with respect to funding provisions such as § 30(A), Congress must "'speak[] with a clear voice,' and manifest[] an 'unambiguous'

intent to confer individual rights" for such statutes to be privately enforceable. *Gonzaga*, 536 U.S. at 280 (quoting *Pennhurst State Sch. & Hosp. v Halderman*, 451 U.S. 1 (1981)). Requiring clear and unambiguous evidence of congressional intent to confer individualized rights prevents the exercise by the judiciary of powers belonging to the legislative branch (with which lies the power to enact laws and to provide for their enforcement), and the executive branch (with which falls the duty to "take Care that the Laws be faithfully executed"). *See Sandoval*, 532 U.S. at 286; *Davis v. Passman*, 442 U.S. 228, 241 (1979); U.S. Const., art. II, § 3. That evidence is lacking here, as Respondents concede. *Sanchez*, 416 F.3d at 1059-62. Applying *Gonzaga*, *Pennhurst*, and *Sandoval* will ensure that Congress's intention to provide for centralized administrative enforcement of § 30(A) by HHS is respected rather than undermined.

2. Respondents cannot avoid these precedents by characterizing their claims as "constitutional." It is true this Court has explained that, in contrast to statutory rights, "the judiciary is . . . the primary means through which [constitutional] rights may be enforced." *Davis*, 442 U.S. at 241. There are, however, no constitutional "rights" at issue here. The Supremacy Clause, the only provision of the Constitution upon which Respondents rely, does not confer substantive rights. *Dennis v. Higgins*, 498 U.S. 439, 450 (1991) (in contrast to the Commerce Clause, the Supremacy Clause is "'not a source of any federal rights'"); *Chapman v. Houston Welfare Rights Org.*, 441 U.S.

600, 613-15 (1979); *Golden State Transit Corp. v. City of Los Angeles*, 493 U.S. 103, 107-08 (1989).

The cases upon which Respondents rely confirm only that the Supremacy Clause supplies a rule of decision. *See, e.g.*, *Cal. Pharm.* Resp. Br. 22-23. That the Supremacy Clause supplies a rule of decision in suits asserting conflicts between state and federal law does not render such suits "constitutional." As the Court explained in *Swift & Co. v. Wickham*, "[t]he declaration of the supremacy clause gives superiority to valid federal acts over conflicting state statutes[,] but *this superiority for present purposes involves merely the construction of an act of Congress*, not the constitutionality of the state enactment." 382 U.S. 111, 121 (1965) (emphasis added, internal quotations omitted). Thus, in *Swift*, this Court held that the claim that a state regulatory statute violated a federal statute was not "upon the ground of the unconstitutionality of such statute," a requirement for a three-judge tribunal under former 28 U.S.C. § 2281. *Id.* at 126-27; *see also Chapman*, 441 U.S. at 612-15 (claim that state regulation is invalid because it conflicts with federal statute was not a civil action seeking redress for the deprivation of "any right, privilege or immunity secured . . . by the Constitution of the United States"); *Golden State*, 493 U.S. at 107-08 (similar).[1]

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[1] *Swift* was not contrary to how the Court had treated Supremacy Clause actions for 50 years, *see Cal. Pharm.* Resp.

(Continued on following page)

Respondents' contention that they "are seeking to enforce not the Medicaid Act, but the Supremacy Clause," is a fiction that their own briefs cannot sustain. *Compare Santa Rosa* Resp. Br. 49; *Cal. Pharm.* Resp. Br. 41 ("By contrast, the 'essence' of this suit is *not* to enforce Section 30(A), but to enforce the Supremacy Clause.") *with Santa Rosa* Resp. Br. 1 ("claims in this case" seek to enjoin "reductions in Medicaid reimbursement rates that California enacted in violation of Section 30(A) of the Medicaid Act"); *Cal. Pharm.* Resp. Br. 54 (arguing that § 30(A) may be judicially enforced). In Respondents' view, § 30(A) imposes certain requirements to which California failed to adhere when it enacted the statutes challenged in this case. Through their multiple lawsuits, Respondents seek to enforce those requirements against the State – and enjoin state statutes to remedy the State's alleged non-compliance with the federal requirements. Congress, however, intended HHS, not private entities and courts, to be the arbiter of whether the States are complying with § 30(A); Respondents' casting their claims as "constitutional" cannot override that dispositive intent.

3. Respondents contend that administrative enforcement of § 30(A) is inadequate, and that absent injunctions Medicaid recipients would lose access to services. These arguments are neither legally sufficient

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Br. 32-33, but instead relied on a series of older precedents and overruled a more recent decision, *Kesler v. Department of Public Safety*, 369 U.S. 153 (1962). 382 U.S. at 120-27.

nor factually correct. The Ninth Circuit did not hold that the State violated an "access" standard in § 30(A). Instead, the Ninth Circuit premised its findings of § 30(A) violations on the State's failure to comply with "procedural" requirements of the court's own invention. As discussed in the State's petitions for certiorari, the State introduced hundreds of pages of data, analysis, and sworn declarations to demonstrate that the payments, as reduced, would preserve access while incentivizing the use of more efficient services where available. The Ninth Circuit largely disregarded this evidence as untimely and irrelevant.[2]

Respondents characterize HHS's enforcement powers as "impoten[t]," because, they say, its options are limited to withholding all federal funding if a state is out of compliance with its approved State Plan. *Cal. Pharm.* Resp. Br. 49-50. However, federal law permits HHS to limit its withholding (or disallowance) of federal funds to those parts of the State Plan with which a state is out of compliance. 42 U.S.C. § 1396c; 42 C.F.R. § 430.35(d). Thus, if a state

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[2] That this Court declined to review the Ninth Circuit's atextual "procedural" approach does not mean that it was correct; the Court may have concluded that the issue may resolve itself in light of new rulemaking promised by the United States. And the federal government has not "found that [California's statutory] reductions violate the Act." *Santa Rosa* Resp. Br. 2. It denied the SPAs because of the length of time that had passed since they were submitted, a decision the State has appealed. Br. for the U.S. as Amicus Curiae 2a-3a, *Douglas v. Indep. Living Ctr. of S. Cal.*, No. 09-958 (Dec. 3, 2010).

chooses to implement a rate reduction that is not approved, the state bears the risk that HHS will withhold federal funds related to the noncompliant rate at issue: a "severe" penalty to be sure, but not the total loss of funding that Respondents describe. *See Cal. Pharm.* Resp. Br. 49; *Santa Rosa* Resp. Br. 40 (quoting *Cannon v. Univ. of Chicago*, 441 U.S. 677, 704-06 (1979)). Moreover, most disputes between states and HHS over compliance with funding conditions are resolved through negotiations and settlements that take into account all relevant interests, federal, state, and private – an essential aspect of administrative enforcement that is lost under Respondents' all-or-nothing injunction approach. *See Cal. Pharm. Ass'n v. Dep't of Health & Human Servs.*, No. C-91-0846-DLJ, 1991 U.S. Dist. LEXIS 13891, at *19-20 (Sept. 13, 1991) ("negotiation" is a part of the "enforcement process in use by [HHS] . . . which [is] used to bring states into compliance without a termination of funds"). Contrary to the impotence label that Respondents attempt to attach to HHS's enforcement powers, the administrative process brings to bear "the expertise, uniformity, widespread consultation, and resulting administrative guidance that can accompany agency decisionmaking." *Gonzaga*, 536 U.S. at 292 (Breyer, J., concurring). In any event, any concerns over the adequacy of remedies for federal statutes is a policy determination for Congress to address. *United States v. Locke*, 529 U.S. 89, 117 (2000) ("The issue is not adequate regulation but political responsibility.").

II. PRIVATE PARTIES MAY NOT USE A PREEMPTION THEORY TO ENFORCE § 30(A)

The State's opening brief demonstrated that the Supremacy Clause may supply a rule of decision (i.e., that federal law "trumps" state law when they conflict), but not a cause of action. Pet. Br. 36-40. This Court's preemption cases confirm at most that a federal cause of action may exist where (1) Congress has conferred a federal right; and (2) a party-to-be-regulated seeks to assert federal preemption of state law as a defense to actual or threatened enforcement proceedings (in which case equity may supply the cause of action). Pet. Br. 42-44 & n.14. Even if the Supremacy Clause *could* supply a cause of action where a conflict between federal and state law is alleged, it cannot do so where the only allegation is that a state has failed to satisfy a funding condition, and where such an action would contravene congressional intent. Pet. Br. 46-49.

A. Neither the Supremacy Clause, Nor Equity, Supplies Private Parties with a Cause of Action to Enforce § 30(A)

Respondents now appear to concede that the Supremacy Clause does not create any causes of action, and therefore seek to premise their lawsuits on the federal courts' equity jurisdiction instead.[3] To that

[3] The parties' descriptions of the adoption and operation of the Supremacy Clause are remarkably consistent. *Compare Santa*

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end, they assert that equity vindicates the Supremacy Clause by providing a cause of action for injunctive relief when a party has been injured based on a purported conflict between state and federal law.[4] Under their theory, all that a party needs to demonstrate is Article III standing, and congressional intent is irrelevant. Respondents' arguments fail for several reasons.

1. Respondents do not satisfy the criteria for federal equity jurisdiction applied in this Court's preemption cases: existence of a federally conferred *right*, or assertion of federal preemption as a *defense* to purportedly invalid regulation. Respondents contend that the latter "limitation on the authority of the federal courts is not supported by history or precedent." *Dominguez* Resp. Br. 5. However, *both* these criteria were satisfied in *Ex parte Young*, 209 U.S. 123 (1908), and one or both of these criteria were satisfied in virtually all of the sixty-one preemption cases set forth in Respondents' appendix. *See Dominguez* Resp. Br. App.

a. Respondents repeatedly invoke *Young* to support the proposition that a standalone equity cause of

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Rosa Resp. Br. 13-18 *with* Pet. Br. 36-41. Respondents then argue that "[a] private right of action . . . is necessary to satisfy this constitutional purpose," i.e., that the judiciary rule conflicting state laws "void" (*Santa Rosa* Resp. Br. 14), but this leap in logic is not supported by history or this Court's precedents.

[4] The Ninth Circuit did not limit itself to equitable remedies, however, but awarded retroactive damages when requested to do so. *Indep. Living* Pet. App. 29-37, 46-47.

action exists to vindicate the supremacy of federal law. In *Young*, however, plaintiffs sued to protect infringement of their constitutional "rights," a circumstance not present here. Moreover, *Young* does not represent an unbounded federal equitable power to enjoin state officials, but rather a well-established bill in equity to restrain proceedings at law. *See Va. Office for Prot. & Advocacy v. Stewart*, 131 S. Ct. 1632, 1642-44 (2011) (Kennedy, J., concurring); John Harrison, *Ex parte Young*, 60 Stan. L. Rev. 989 (2008).

A party could obtain an injunction of actual or imminent enforcement proceedings where, *inter alia*, the party had a defense to those proceedings but a legal judgment in defendant's favor would not provide an adequate remedy. 2 John Norton Pomeroy, *A Treatise on Equitable Remedies* § 646 (1905) (*Equitable Remedies*). When the defense was based on the invalidity of state law, a party could demonstrate lack of an adequate legal remedy if it faced a Hobson's choice: either comply with the purportedly invalid law, or else violate that law and be exposed to fines, penalties, or other liability. *Morales v. Trans World Airlines*, 504 U.S. 374, 381 (1992); *see also Pub. Utils. Comm'n v. United Fuel Gas Co.*, 317 U.S. 456, 469 (1943); *Terrace v. Thompson*, 263 U.S. 197, 215-16 (1923); *Young*, 209 U.S. at 163-64. In addition, equitable relief was available in such cases only "to protect *property rights and the rights of persons* against injuries otherwise irremediable." *Terrace*, 263 U.S. at 214 (emphasis added).

Plaintiffs in *Young* satisfied all of these requirements, and their use of the anti-suit injunction is confirmed by Justice Peckham's framing of the issue: whether a party could "obtain freedom from suits, civil or criminal," when faced with impending enforcement of an unconstitutional state law. 209 U.S. at 149. Additionally, the Court found that plaintiffs had no adequate remedy at law, emphasizing the difficulty of finding a railroad employee willing to defy the law as well as the fines the railroad company would incur for violating the act. *Id.* at 163-64. Immediately after *Young* was decided, the case was cited consistently for the limited proposition that "'individuals, who, as officers of the state . . . *threaten and are about to commence proceedings, either of a civil or criminal nature*, to enforce against parties affected [by] an unconstitutional act, . . . may be enjoined by a federal court of equity from such action.'" *Cavanaugh v. Looney*, 248 U.S. 453, 456 (1919) (emphasis added); *Home Tel. & Tel. Co. v. City of Los Angeles*, 227 U.S. 278, 293 (1913); *W. Union Tel. Co. v. Andrews*, 216 U.S. 165, 166 (1910). The present cases, by contrast, do not involve the impairment of personal or property rights, a defense to state regulation, or any "Hobson's choice," and Respondents do not contend otherwise.[5]

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[5] The well-pleaded complaint rule does not support Respondents' claim that *Young* recognized a "federal cause of action to enjoin state officials who come into conflict with the Constitution or federal laws." *Cal. Pharm.* Resp. Br. 21. Rather, the equity plaintiff's preemptive federal defense satisfied the well-pleaded complaint rule because a bill in equity had to "tell the entire

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Respondents' reliance on *Osborn v. Bank of the U.S.*, 22 U.S. (9 Wheat.) 738 (1824), which they characterize as a precursor to *Young*, is similarly misplaced. *See Cal. Pharm.* Resp. Br. 20-21. *Osborn* and *Young* did not represent the same cause of action. Instead, as the Court explained in *Young*, *Osborn* was a suit to enjoin "trespass upon . . . tangible property," whereas *Young* was "a bill filed to prevent the commencement of suits." 209 U.S. at 167. Moreover, plaintiffs in *Osborn* asserted infringement of federally protected "rights and privileges," and Congress had expressly authorized suit in federal court. 22 U.S. at 825, 839. Far from supporting Respondents' position, *Osborn* demonstrates no more than that federal equity jurisdiction may be available when a party's claims fit within a pre-existing cause of action, involve infringement of federal rights, and do not conflict with congressional intent – none of which can be said about the present actions.

b. The sixty-one preemption cases cited by Respondents confirm, rather than undercut, the limitations on federal equity jurisdiction. *See Dominguez* Resp. Br. App. In forty-seven of the sixty-one cases, plaintiffs asserted federal preemption as an anticipatory *defense* to state enforcement of purportedly invalid state regulation of their conduct. *See Dominguez*

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story" of why the defendant's action was unlawful. Alfred Hill, *Constitutional Remedies*, 69 Colum. L. Rev. 1109, 1129 (1969); *see also* 1 Roger Foster, *A Treatise on Federal Practice in Civil Cases* § 67 (1892).

Resp. Br. App. (Nos. 1-4, 6, 8-11, 13, 15-16, 18, 20-34, 35-43, 46-54, 57).[6] In addition, federal "rights" may have been lurking in a number of these cases.[7] And sixteen of these forty-seven cases involved express pre-emption clauses, a type of federal statute from which

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[6] *Lawrence County v. Lead-Deadwood Sch. Dist.*, 469 U.S. 256 (1985), is included because preemption was raised defensively by a county in a state court lawsuit brought by a school district to enforce a state statute.

[7] *See, e.g., Watters v. Wachovia Bank, N.A.*, 550 U.S. 1, 12 (2007) ("We have 'interpret[ed] grants of both enumerated and incidental "powers" to national banks as grants of authority not normally limited by, but rather ordinarily pre-empting, contrary state law.' "); *Cal. Coastal Comm'n v. Granite Rock Co.*, 480 U.S. 572, 584 (1987) (" 'rights granted by the Mining Law of 1872' "); *Lawrence*, 469 U.S. at 258 (federal statute authorized a local unit to "use the payment for any governmental purpose"); *Brown v. Hotel & Rest. Employees & Bartenders Int'l Union Local 54*, 468 U.S. 491, 501 (1984) ("[S]tate law which interferes with the exercise of these federally protected rights . . . is pre-empted."); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96 n.14 (1983) ("It is beyond dispute that federal courts have jurisdiction over suits to enjoin state officials from interfering with federal rights."); *Malone v. White Motor Corp.*, 435 U.S. 497, 502 (1978) (claim that state law " 'interferes with the right of Plaintiffs to free collective bargaining under federal law' "); *Douglas v. Seacoast Prods., Inc.*, 431 U.S. 265, 281 (1977) (federal license "transfer[s] to the licensee 'all the right' which Congress has the power to convey"); *Hines v. Davidowitz*, 312 U.S. 52, 68 (1941) ("[T]his legislation deals with the rights, liberties, and personal freedoms of human beings. . . ."); *Cummings v. City of Chicago*, 188 U.S. 410, 411-12 (1903) ("The controlling question . . . is whether the plaintiffs have the right, in virtue of certain legislation of Congress and of certain action of the Secretary of War . . . to proceed with the proposed work. . . ."); *see also N.Y. Tel. Co. v. N.Y. State Dep't of Labor*, 440 U.S. 519 (1979) (asserting *Machinists*-type preemption claim); *Golden State*, 493 U.S. 103.

it may be possible to infer congressional intent to permit a private right of action. *Dominguez* Resp. Br. App. (Nos. 1, 3, 4, 6, 8, 9, 11, 15, 16, 18, 20, 22, 23, 26, 32, 40).

Of the cases that remain, five involved challenges to state or local taxation of a federal instrumentality, or of land that retained a federal interest or character. *Dominguez* Resp. Br. App. (Nos. 55, 56, 58, 59, 61). These cases, too, do not support Respondents. At the time these cases were filed, this Court had recognized, though carefully circumscribed, the circumstances in which a bill in equity could be brought to enjoin illegal state tax collection. *See Boise Artesian Hot & Cold Water Co. v. Boise City*, 213 U.S. 276, 282-83, 285 (1909). Based on this well-established authority, state officials did not dispute federal equity jurisdiction in such cases. *See Choctaw, Okla., & Gulf R.R. Co. v. Harrison*, 235 U.S. 292, 296 (1914). Respondents, by contrast, are not seeking to enjoin collection of an illegal tax.[8]

That this Court assumed the existence of a cause of action in the few remaining cases does not mean that there was one. *See Sandoval*, 532 U.S. at 287 (describing "*ancien régime*," in which "rights" were not

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[8] In addition, the parties in such suits appear to have been asserting federally protected rights not to be subject to state taxation. *Osborn*, 22 U.S. at 838; *see also Boise*, 213 U.S. at 282 (an equity court will not interfere with state taxing efforts "in . . . cases where the Federal rights of the persons could otherwise be preserved unimpaired" through, *inter alia*, remedies at law).

analyzed with the same rigor). That said, a number of the remaining cases appear to have involved individualized, if unexamined, federal rights upon which the state purportedly was infringing.[9] *Crosby v. National Foreign Trade Council*, 530 U.S. 363 (2000), on which Respondents heavily rely, arose in the highly specialized context of foreign relations. *See Hillsborough County, Fla. v. Automated Med. Labs., Inc.*, 471 U.S. 707, 719 (1985). Had the issue been raised, the Court might have inferred the requisite intent to permit private enforcement based on this unique context, or held that no private action existed. Preemption in *Foster v. Love*, 522 U.S. 67 (1997), upon which Respondents also heavily rely, was premised on congressional action pursuant to the Elections Clause; again,

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[9] *California Department of Human Resources Development v. Java*, 402 U.S. 121 (1971), was expressly brought under § 1983, and 42 U.S.C. § 503(a)(1) has been held to be privately enforceable. *See* Br. of the Appellants, S. Ct. No. 70-507, 1970 WL 136861, at *1-2 (Dec. 2, 1970); *Zambrano v. Reinert*, 291 F.3d 964 (7th Cir. 2002). Plaintiffs in *Arkansas Department of Health & Human Services v. Ahlborn*, 547 U.S. 268 (2006), sought to enforce 42 U.S.C. § 1396p, which prohibits states from imposing a lien "against the property of any individual prior to his death." While *Rosado v. Wyman*, 397 U.S. 397 (1970), did not address plaintiffs' cause of action, the Court clearly assumed plaintiffs had a right to enforce the federal statutory provisions at issue. *See Maine v. Thiboutot*, 448 U.S. 1, 4 (1980); *id.* at 30 (Powell, J., dissenting); *Edelman v. Jordan*, 415 U.S. 651, 676 (1974); *id.* at 690 (Marshall, J., dissenting). One additional case involves the NLRA, a federal statute conferring rights enforceable under 42 U.S.C. § 1983. *Bldg. & Constr. Trades Council v. Associated Builders & Contractors of Mass./R.I.*, 507 U.S. 218 (1993); *Golden State*, 493 U.S. 103.

had the issue been raised, the Court might have inferred the requisite intent from this specialized context, *see Gonzalez v. Arizona*, 624 F.3d 1162, 1174 (9th Cir. 2010), or simply held that plaintiff voters lacked a private cause of action. *Cf. Lance v. Coffman*, 549 U.S. 437 (2007) (Colorado voters lacked standing to challenge provision of Colorado Constitution as violating the Elections Clause).[10]

Finally, in the sixty-one cases, preemption actions were brought in service of congressional intent, most frequently to prevent state regulatory action from undermining the uniformity of a federal regulatory scheme. *See, e.g., Ray v. Atl. Richfield Co.*, 435 U.S. 151, 165 (1978) ("Enforcement of the state requirements would at least frustrate what seems to us to be the evident congressional intention to establish a uniform federal regime controlling the design of oil tankers."); *City of Burbank v. Lockheed Air Terminal Inc.*, 411 U.S. 624, 625 (1973); *Campbell v. Hussey*, 368 U.S. 297, 300-01 (1961). By contrast, Respondents' effort to maintain a private cause of action is *contrary* to congressional intent, and would lead to *disunity* rather than uniformity in the interpretation of

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[10] *Gilman v. City of Philadelphia*, 70 U.S. (3 Wall.) 713, 719-21 (1865), cited by Respondents, did not involve a federal claim per se, as federal jurisdiction was based on diversity of citizenship, and plaintiff was asserting, *inter alia*, a nuisance claim, in addition to infringement of unspecified "rights." In *Dalton v. Little Rock Family Planning Services*, 516 U.S. 474 (1996) (per curiam), the Court only granted certiorari on the scope of the injunctions; it did not address the underlying claim of preemption.

federal law. Perhaps more striking is that, in some of these cases, state efforts to supplement remedies provided by Congress were held preempted because Congress intended for centralized administrative enforcement. *See, e.g., Wis. Dep't of Indus., Labor & Human Relations v. Gould Inc.*, 475 U.S. 282, 289-90 (1986) ("The NLRA, in contrast, was designed in large part to 'entrus[t] administration of the labor policy for the Nation to a centralized administrative agency.' "); *see also N.Y. Tel. Co.*, 440 U.S. at 528. Respondents invoke preemption here to achieve *exactly the opposite* result – to *compel* a supplemental remedy *in contravention* of congressional intent for centralized administrative enforcement.

c. Respondents resort, finally, to general equitable principles in an effort to find a vehicle for their lawsuits, claiming that equity courts would grant relief to "anyone harmed" so long as the case "otherwise fell within the federal courts' jurisdiction." *Cal. Pharm.* Resp. Br. 27; *Dominguez* Resp. Br. 11. Their theory, thus, contains no limiting principles whatsoever, beyond Article III standing. Even were Respondents correct as a historical matter, the availability of equitable relief to enforce federal statutes has long been circumscribed by such concerns as separation-of-powers, respect for state sovereignty, and fidelity to congressional intent. *See, e.g., Sandoval*, 532 U.S. 275; *Blessing v. Freestone*, 520 U.S. 329 (1997); *Seminole Tribe of Fla. v. Florida*, 517 U.S. 44 (1996); *Pennhurst*, 451 U.S. 1; *see also Gebser v. Lago Vista Indep. Sch. Dist.*, 524 U.S. 274, 287 (1998) (the "contractual

nature" of Spending Clause laws "has implications for our construction of the scope of available remedies"). Private parties in *Sandoval*, *Blessing*, *Seminole*, and *Pennhurst* all claimed injury and sought equitable relief, and in all these cases that relief was denied.[11]

Respondents' conception of equity jurisdiction is, in any event, ahistorical. Equity courts were not "roving commission[s] to do justice beyond the law," but provided relief through established forms of proceeding. Philip Hamburger, *Law and Judicial Duty* 338-39 (2008); *see also Rees v. City of Watertown*, 86 U.S. (19 Wall.) 107, 122 (1873); Anthony J. Bellia Jr., *Article III and the Cause of Action*, 89 Iowa L. Rev. 777, 784-92 (2004). A claim had to fit with certain remedies-based causes of action, such as a bill to restrain proceedings at law or a bill to restrain the assessment of taxes. *Bellia*, *supra*, at 784-86; *see also* 1 Foster, *supra*, § 210 (describing circumstances in which an injunction may issue). Respondents' claims fit into neither the bill to restrain proceedings at law nor any of the remedies-based causes of action in the federal equity cases they cite. *See Dominguez* Resp. Br. 7-10, 17, 39-40 (citing, among others, cases filed

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[11] If it was true that the only requirement for a federal action "to bring a government official into compliance with federal law" was standing, *see Cal. Pharm.* Resp. Br. 20, many of the Court's decisions on whether a federal statute could be privately enforced under § 1983 were mere sport. In many of these cases, private parties sought injunctive relief, and it could have been ordered under Respondents' theory without resort to § 1983. *See* Amicus Br. of the U.S. 26-27.

under bills to restrain nuisance, to enjoin the collection of taxes, to enjoin trespass, and to restrain proceedings at law).

Respondents thus urge precisely the vision of equity practice that early commentators and this Court have warned against. *See* 1 Joseph Story, *Commentaries on Equity Jurisprudence* § 19 (14th ed. 1918) ("If indeed a Court of Equity in England did possess the unbounded jurisdiction which has been thus generally ascribed to it . . . it would be the most gigantic in its sway, and the most formidable instrument of arbitrary power, that could well be devised."); *Heine v. Levee Comm'rs*, 86 U.S. (19 Wall.) 655, 658 (1873) (court of equity may not "depart from all precedent and assume an unregulated power of administering abstract justice at the expense of well-settled principles"). It was a maxim of equity that "[e]quity follows the law." 1 John Norton Pomeroy, *A Treatise on Equity Jurisprudence* § 425 (3d ed. 1905) (*Equity Jurisprudence*). A court of equity could not "create a remedy in violation of law, or even without the authority of law." *Rees*, 86 U.S. at 122. Thus, "where a particular remedy is given by the law, and that remedy bounded and circumscribed by particular rules, it would be very improper" for a court of equity to "take it up where the law leaves it, and to extend it further than the law allows." 1 Pomeroy, *Equity Jurisprudence*, *supra*, § 425; *see also I.N.S. v. Pangilinan*, 486 U.S. 875, 883 (1988) ("'[C]ourts of equity can no more disregard statutory and constitutional requirements and provisions than can courts of law.'"); *Rees*, 86 U.S. at 122.

Here, the administrative remedy provided by Congress, "bounded and circumscribed by particular rules," may not be extended in the absence of congressional intent.

Finally, Respondents cannot allege the impairment of right or title that is required for equitable relief against a state actor, such as a right to real and personal property, rights in person, and statutory rights. *See Tenn. Elec. Power Co. v. Tenn. Valley Auth.*, 306 U.S. 118, 137 (1939); *Terrace*, 263 U.S. at 214; 1 Pomeroy, *Equitable Remedies*, *supra*, § 323. Plaintiffs in the cases cited by Respondents satisfied this requirement.[12] Respondents do not – indeed, the very premise of these cases is that they lack any rights under the Spending Clause provision at issue.

d. In light of these precedents, Respondents now claim that the present cases involve a defense to state regulation of their primary conduct. *Santa Rosa* Resp. Br. 34-35; *Cal. Pharm.* Resp. Br. 27. They cite California Welfare and Institutions Code § 14019.4, a state law that prohibits them from seeking reimbursement directly from Medicaid beneficiaries. However, the present lawsuits challenge the State's rate reductions,

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[12] *See, e.g., Scott v. Donald*, 165 U.S. 107 (1897) (bill to enjoin state confiscation of plaintiff's liquor); *Pennoyer v. McConnaughy*, 140 U.S. 1, 25 (1891) (bill to enjoin defendants from selling and conveying land to which plaintiff asserted title); *Poindexter v. Greenhow*, 114 U.S. 270, 283 (1885) (action of detinue against a tax collector for return of personal property); *Hughes v. Trustees of Morden Coll.*, 27 Eng. Rep. 973 (Ch. 1748) (bill to enjoin trespass on land in plaintiff's possession).

not the State's enforcement of § 14019.4. Further, Respondents have never claimed, and have therefore waived any argument, that § 14019.4 conflicts with federal law.

2. Respondents contend that they may assert a standalone cause of action to vindicate the proper "structural" relationship between the federal and state governments, but the cases upon which they rely do not support their theory. In *Bond v. United States*, 131 S. Ct. 2355 (2011), and related cases, private parties raised federal constitutional provisions as a *defense* to actual or anticipated enforcement of a state or federal statute that otherwise would have regulated plaintiff's conduct and subjected plaintiff to penalties. Thus, while this Court permitted a criminal defendant in *Bond* to raise the Tenth Amendment as a defense to enforcement of a federal criminal statute against her, this Court has refused to allow private parties to sue under the Tenth Amendment where the defensive component was lacking. *Tenn. Elec.*, 306 U.S. at 144. Indeed, in *Bond*, this Court explained that the power companies in *Tennessee Electric* lacked a cause of action to challenge the competitive operations of the TVA precisely because the state had not sought to *regulate* plaintiffs (and penalize any noncompliance), but merely to *compete* with them. 131 S. Ct. at 2362. Similarly, in *Free Enterprise Fund v. Public Company Accounting Oversight Board*, 130 S. Ct. 3138 (2010), in which an investigated entity sought to challenge the creation of a federal oversight board on separation-of-powers grounds, the Court expressly acknowledged

the defensive posture of the case, explaining that "[w]e normally do not require plaintiffs to 'bet the farm . . . by taking the violative action' before 'testing the validity of the law.'" 130 S. Ct. at 3151.[13]

Respondents also cite, in support of their "structural" cause-of-action theory, dissenting opinions in *Dennis v. Higgins* and *Golden State*. Again, however, these dissents discussed the *defensive* use of Constitution-derived "structural" immunities to invalid state regulation. *See, e.g.*, *Dennis*, 498 U.S. at 451-65 (Kennedy, J., dissenting); *Golden State*, 493 U.S. at 113-19 (Kennedy, J., dissenting). While the *Golden State* dissent discussed the existence of this type of immunity, it did not address the circumstances under which it could be asserted. In *Dennis*, however, Justice Kennedy clarified that he had a defensive suit in mind when he wrote the *Golden State* dissent. 498 U.S. at 462-63 (Kennedy, J., dissenting) (under the reasoning of the *Golden State* dissent, the party in *Higgins* could have "rel[ied] on the unconstitutionality [under the Commerce Clause] of the tax in defending a collection action brought by the State"). More recent opinions have further emphasized the defensive nature of such suits against the States.

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[13] *Free Enterprise Fund* did not "expressly uph[o]ld 'an implied private right of action directly under the Constitution to challenge governmental action under the Appointments Clause or separation-of-powers principles.'" *Santa Rosa* Resp. Br. at 25 (quoting 130 S. Ct. at 3151 n.2 (quoting Brief for the United States 22)). The quote-within-a-quote was a party's characterization of the issues, not the Court's holding.

Va. Office for Prot. & Advocacy, 131 S. Ct. at 1642 (Kennedy, J., concurring) ("That negative injunction [in *Ex parte Young*] was nothing more than the preemptive assertion in equity of a defense that would otherwise have been available in the State's enforcement proceedings at law."); *see also id.* at 1643 ("*Verizon Md.* itself was an easy case, for it involved the same kind of preenforcement assertion of a defense that was at issue in *Young*.").

In any event, the present cases do not involve purported "structural" violations. By their nature, "structural" violations involve state "encroachment on Federal powers," and the remedy when such encroachment occurs is to declare such state action "void." *See Higgins*, 498 U.S. at 443 n.4 (quoting Rep. Shellabarger, Cong. Globe, 42nd Cong., 1st Sess., App. 69-70 (1871)). Here, the challenged state reductions do not "encroach" on any federal power, but at most amount to a purported failure to satisfy a federal funding condition. *See* Part II.B, *infra*.

3. Respondents also cite, as authority to enjoin state officials who are purportedly acting in excess of their authority, cases challenging *federal* government action under the "non-statutory review" doctrine. *Cal. Pharm.* Resp. Br. 23-25. Cases against federal officials, however, do not implicate the same federalism concerns that govern lawsuits against a *state* in a *Spending Clause* context – concerns that lie at the heart of the limitations on such suits recognized in *Gonzaga* and *Pennhurst*. Moreover, these claims, too, are subject to the requirements that apply to other

equitable causes of action, including, *inter alia*, irreparable injury to personal property, rights to real and personal property, rights in person, and statutory rights. *See, e.g., Am. Sch. of Magnetic Healing v. McAnnulty*, 187 U.S. 94, 110 (1902) (Postmaster General's withholding of mail "violate[d] the property rights of the person whose letters are withheld"); *Harmon v. Brucker*, 355 U.S. 579, 582 (1958) (per curiam) ("[T]he claims presented in these cases may be entertained by the District Court because petitioners have alleged judicially cognizable injuries.").[14] Respondents have asserted no such legally cognizable right or interest. Part II.A.1.c, *supra*. And, in both *McAnnulty* and *Harmon*, the administrative review process had been completed, which enabled the Court to conclude there were no other means to redress plaintiffs' injuries. *Harmon*, 355 U.S. at 580; *McAnnulty*, 187 U.S. at 122. Here, by contrast, the administrative review process remains pending and, were HHS to rule against the State, it could order the State to provide additional retroactive funding to avoid forfeiting federal funds.[15]

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[14] *Dalton v. Specter*, 511 U.S. 462, 474 (1994), also cited by Respondents, did not hold that plaintiffs had a cause of action, but merely "assume[d so] for the sake for argument," a point that Respondents' truncated quotation obscures. *Compare Cal. Pharm.* Resp. Br. 24 *with* 511 U.S. at 474.

[15] That the State, in such a circumstance, would have the *option* of choosing *not* to make additional payments, and thereby forfeit federal funds, is an essential feature of Spending Clause legislation. Thus, the State's possible selection of that option

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4. Respondents suggest that their inability to satisfy the criteria guiding when federal equity courts would hear preemption claims goes to the merits of a cause of action rather than its existence. *Santa Rosa* Resp. Br. 35; *Dominguez* Resp. Br. 48 n.24. However, the "concept of a 'cause of action' is employed specifically to determine who may judicially enforce . . . statutory rights or obligations." *Davis*, 442 U.S. at 239; *see also id.* ("If a litigant is an appropriate party to invoke the power of the courts, it is said that he has a 'cause of action.'"). Because Congress has not included Respondents among those who may enforce obligations owed by the State to the federal government under § 30(A), they lack a cause of action.

B. Preemption Is Not Available to Enforce § 30(A), a Funding Condition, in Contravention of Congressional Intent

Even if private parties could bring standalone preemption claims to enforce federal statutes in appropriate cases, private preemption claims would not be available to Respondents to enforce § 30(A). This is because (1) Respondents' cases lack the "repugnancy" element so critical to the Supremacy Clause; and (2) preemption claims may not be recognized in contravention of congressional intent regarding how federal statutes are to be enforced.

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would not render an administrative remedy "inadequate" to justify the exercise of equity jurisdiction.

1. Respondents cannot satisfy the predicate for the type of suit they claim exists: a conflict between state and federal law. A state may fail to satisfy a Medicaid funding requirement, *but still be in compliance with federal law*. Section 30(A) imposes a condition for receipt of federal funds, while *other* federal laws direct what happens when a state fails to satisfy a funding condition. *See, e.g.*, 42 U.S.C. § 1396c; 42 C.F.R. §§ 430.33, 430.35, 430.38, 430.42, 430.48. Although it is alleged that California has breached a funding condition, it is not alleged that California has violated any law governing the consequences for that breach, nor could Respondents assert such a claim; such a claim would be unripe (even assuming Respondents had standing to assert it), as the administrative process is still pending with respect to the reductions at issue. In short, an alleged breach of a funding condition, by itself, does not supply the type of conflict between federal and state laws that implicates the Supremacy Clause. Rather, as demonstrated in Petitioners' opening brief, the remedies for any breach are governed by the contractual relationship between the State and Federal governments, as set forth in statutes, regulations, and state plans. Pet. Br. 46-49.

And while Respondents are no doubt correct that it is wrong "to imply that *all* contract-law rules apply to Spending Clause legislation," *Barnes v. Gorman*, 536 U.S. 181, 186 (2002), this Court in *Barnes* also noted that it has "repeatedly characterized . . . Spending Clause legislation as 'much in the nature of a

contract: in return for federal funds, the [recipients] agree to comply with federally imposed conditions.'" *Id.* Among those conditions are the sanctions for non-compliance. Respondents' insistence that "the Supremacy Clause applies to *all* 'Laws of the United States,'" including Spending Clause enactments, is a non sequitur. *Dominguez* Rep. Br. 22. Here, that law provides that "State plans that do not meet [§ 30(A)'s] requirements are to be defunded by the Secretary – they are not void under the Supremacy Clause." *PhRMA v. Walsh*, 538 U.S. 644, 680 n.3 (2003) (Thomas, J., concurring in judgment). To be sure, as Respondents observe, this Court has sometimes described state laws that breached Spending Clause conditions as being "pre-empted." That may have served as a convenient, albeit inaccurate, shorthand. Chief Justice Burger was correct when he stated that "adherence to the provisions of [a Spending Clause provision] is in no way mandatory upon the States under the Supremacy Clause. The appropriate inquiry . . . should be simply whether the State has indeed adhered to the provisions and is accordingly entitled to utilize federal funds in support of its program." *Townsend v. Swank*, 404 U.S. 282, 292 (1971) (Burger, C.J., concurring in the result).

This does not mean that *all* provisions of the Medicaid Act (or other Spending Clause statutes) are unenforceable by private parties. Numerous provisions of the Medicaid Act have been held to "clearly" and "unambiguously" confer "rights" on private parties that are judicially enforceable. Pet. Br. 46 n.17. Such

lawsuits are not premised on abstract concerns about federal-state conflicts or federal-state structural relationships, but rather on the actual deprivation of concrete federal "rights." When created by Congress, such rights become a part of a state's quasicontractual relationship with the federal government. While private parties may sue to protect such "rights," that is not the type of lawsuit at issue here.

2. Further, private preemption claims are not available *in spite* of Congress's intent regarding how federal statutes are to be enforced, but only *in service* of that intent. *Chamber of Commerce of U.S. v. Whiting*, 131 S. Ct. 1968, 1985 (2011) (plurality opinion) ("[I]t is Congress rather than the courts that preempts state law."); *Wyeth v. Levine*, 129 S. Ct. 1187, 1194 (2009) ("'[T]he purpose of Congress is the ultimate touchstone in every pre-emption case.'"); *see, e.g.*, *Gould*, 475 U.S. at 289-90 (preempting supplemental state law remedy as inconsistent with administrative enforcement of federal statute). As the United States explains, Amicus Br. of the U.S. 31-32, Congress has put HHS, not private parties, in charge of holding states to their obligations to balance the policy objectives in § 30(A) when setting rates, a legislative delegation that the courts must respect.

Respondents mine the legislative history of § 30(A) and other provisions of the Medicaid Act for expressions of congressional intent to provide for private enforcement. Their effort fails on multiple levels. First, it cannot be reconciled with their longstanding concession that, as the Ninth Circuit held in *Sanchez*

v. Johnson, § 30(A) does not create any privately enforceable rights. It is far too late in the day for Respondents to call into question the very predicate of the issue now before this Court. Second, even if they existed, expressions of intent buried deep in the legislative history could not supply the "clear" and "unambiguous" intent to confer a privately enforceable "right" required for private enforcement of federal funding conditions. *See Gonzaga*, 536 U.S. at 280; *supra*, Part I.

Third, and in any event, no such evidence of intent resides in the legislative history of § 30(A). Respondents and their amici quote extensively from a committee report prepared in connection with the Omnibus Reconciliation Act of 1981, but the language on which they rely appears in a section of the report describing amendments to Medicaid's "freedom-of-choice" provision, 42 U.S.C. § 1396a(a)(23), *not § 30(A)*, and specifically refers to the "rights of Medicaid beneficiaries or participating providers." *Cal. Pharm.* Resp. Br. 54-55 (citing H.R. Rep. No. 97-158, Vol. II, at 301 (1981)); *Indep. Living* Resp. Br. 20-21, 54-55; Amicus Br. of Former HHS Officials 15; Amicus Br. of AMA 13. Unlike § 30(A), the freedom-of-choice requirement (giving Medicaid recipients the power to choose their doctors) has been held to confer private, judicially enforceable, rights on beneficiaries. *See, e.g., Harris v. Olszewski*, 442 F.3d 456 (6th Cir. 2006).

Respondents also note that Congress amended § 30(A) in 1989 to supplement the factors that states must balance as part of their ratemaking. *Cal. Pharm.*

Resp. Br. 55. However, they did not contend below, and do not now contend, that the 1989 amendment conferred any "rights" or otherwise evinced congressional intent that it be judicially enforced by private parties.[16] Seven members of Congress urge that "Congress has expressly chosen to maintain § 30A knowing full well that it provides enforceable rights." Amicus Br. of Members of Congress 5. However, Congress's failure to enact a legislative "fix" to the host of circuit decisions holding that § 30A does *not* confer rights suggests otherwise.

Respondents also cite a committee report demonstrating Congress's intention to preserve providers' right to sue for injunctive relief under the Boren Amendment following repeal of that statute's Eleventh Amendment waiver requirement. *Cal. Pharm.* Resp. Br. 51-52; *see* S. Rep. 94-1240, at 4 (1976). Preservation of some form of private enforcement of Boren following the waiver repeal made sense, given that, unlike § 30(A), Congress *"designed [Boren] to afford providers access to a judicial remedy for purposes of enforcing their legal rights."* S. Rep. No. 94-1240, *supra*, at 3 (emphasis added). Significantly, no such similar expressions of legislative intent exist with respect to § 30(A) regarding either "legal rights" or their enforcement. To the contrary, substantial differences

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[16] Contrary to Respondents' assertions, the State does not concede that this language did more than add a new objective to those that States must balance in establishing rates. *See Cal. Pharm.* Resp. Br. 56.

in the text and structure of Boren and § 30(A) suggest that Congress had entirely different intentions with respect to how the two provisions would be enforced, and by whom. Boren required states to set payments at a level that was "reasonable and adequate" to "meet the costs" of efficiently and economically operated providers, and to "find[ ] and make[ ] assurances satisfactory to the Secretary" that the standard was satisfied. *Wilder*, 496 U.S. at 503. By contrast, § 30(A) does not set an objective, judicially enforceable standard for the States' Medicaid ratemaking, nor does it make state findings – and HHS approval of those findings – a precondition to valid rates.[17] Finally, that Congress did not require the States to waive their Eleventh Amendment immunity to claims under § 30(A), as it previously did for Boren, and has done in connection with other federal statutes, *see*, *e.g.*, 20 U.S.C. § 1403(a)-(b), is consistent with the absence of any privately enforceable rights, and therefore supports Petitioners, not Respondents.

Congressional enactments in the wake of *Suter v. Artist M.*, 503 U.S. 347 (1992), to confirm the private

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[17] Boren's express requirement of HHS approval of a state's findings may explain why some courts interpreted Boren as requiring states to obtain SPA approval prior to changing their rates. *See, e.g., Exeter Mem. Hosp. Ass'n v. Belshe*, 145 F.3d 1106 (9th Cir. 1998). No statute or regulation currently in effect imposes such a requirement on the States, let alone confers on providers or beneficiaries a right to judicially enforce it. *See* Supplemental Brief of Petitioners, *Douglas v. Cal. Pharm. Ass'n*, S. Ct. No. 09-1158 (Dec. 20, 2010).

enforceability of *some* state plan components, do not reflect congressional intent that *all* provisions of such plans, or of the Social Security Act generally, be privately enforceable. *See Cal. Pharm.* Resp. Br. 53; *Dominguez* Resp. Br. 25-26. Even as Congress enacted the *Suter* fix, it directed that this legislation not be otherwise construed "to limit *or expand* the grounds for determining the availability of private actions," and confirmed that the statute at issue in *Suter* was not privately enforceable. 42 U.S.C. §§ 1320a-2, 1320a-10 (emphasis added); *see also* Amicus Br. for the U.S. 30-31.

Respondents' remaining arguments regarding congressional intent take aim at straw men. Petitioners do not contend that *all* funding conditions in Spending Clause statutes are off-limits to private enforcement, *Santa Rosa* Resp. Br. 36, nor do they contend that Congress has entirely displaced private enforcement of the Medicaid Act. *See Cal. Pharm.* Resp. Br. 46. Rather, Petitioners argue only that private enforcement is limited to those provisions of the Medicaid Act that reflect congressional intent to confer a "right" and a remedy (which § 1983 may supply). That Congress once considered but failed to enact legislation that would have eliminated *all* private Medicaid suits, *Cal. Pharm.* Resp. Br. 58-59, is thus of no moment.

C. Prudential Standing Principles Bar Respondents' Claims

Three different strands of prudential-standing analysis also bar Respondents' claims. Pet. Br. 49-52.

These arguments have been properly preserved for review by this Court.

While it is true that every strand of prudential-standing analysis was not preserved in *every* one of the underlying seven appeals, it is also true that two of the strands (no-third-party-assertion-of-rights and zone-of-interest) were preserved in *at least one or more* of the underlying appeals. *See* Pet. Br. 50 n.19. The third strand, barring "generalized" grievances, was suggested by the Ninth Circuit's analysis rather than by Respondents' pleadings. These prudential standing arguments are "fairly included" in the question presented: "Whether Medicaid recipients and providers may maintain a cause of action under the Supremacy Clause to enforce § 30(A)." S. Ct. Rule 14.1(a).

Turning to the merits: In arguing that Medicaid providers are within the "zone of interest" protected by § 30(A), Respondents conflate the zone-of-interest test that applies under the "generous review provisions" of the Administrative Procedure Act ("APA") with the more rigorous zone-of-interest test that applies outside of that context. *Bennett v. Spear*, 520 U.S. 154, 163 (1997); *Clarke v. Sec. Indus. Ass'n*, 479 U.S. 388, 400 n.16 (1987). Because this is not an APA case, providers must demonstrate that Congress enacted § 30(A) for their "*especial* benefit." *Clarke*, 479 U.S. at 399-400 n.16. This they cannot do.

CONCLUSION

For the foregoing reasons, the judgments below should be reversed.

Dated: September 1, 2011

Respectfully submitted,

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No. 09-1158

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In The
Supreme Court of the United States

DAVID MAXWELL-JOLLY, DIRECTOR OF THE DEPARTMENT OF HEALTH CARE SERVICES, STATE OF CALIFORNIA, ET AL., PETITIONERS,

v.

CALIFORNIA PHARMACISTS ASSOCIATION, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

JOINT SUPPLEMENTAL BRIEF OF RESPONDENTS CALIFORNIA PHARMACISTS ASSOCIATION, ET AL., INDEPENDENT LIVING CENTER OF SOUTHERN CALIFORNIA, ET AL., AND LYDIA DOMINGUEZ, ET AL.

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Respondents, who previously filed separate briefs in opposition, offer this joint supplemental brief to respond to two new assertions made by petitioners with respect to this case in their supplemental brief of December 14, 2010 filed in *Maxwell-Jolly v. Independent Living Center of Southern California, Inc.*, No. 09-958 ("Supp. Br.").

SUPPLEMENTAL REASONS THE PETITION SHOULD BE DENIED

The United States Department of Health and Human Services (HHS) recently disapproved California's proposed state plan amendments (SPAs) that reflected the various rate cuts challenged by respondents. Petitioners claim (Supp. Br. 5-6, 13) that, absent the preliminary injunctions obtained by respondents, the rate cuts would be in effect while their administrative appeal of the disapproval is pending. That claim is not supported by anything in their brief, and there is in fact no support for it.

To the contrary, HHS's disapproval is an independent bar to the rate cuts taking effect. The relevant federal regulation provides that States that participate in the Medicaid program "*must* pay for * * * services using rates determined in accordance with methods and standards specified in an *approved* State plan." 42 C.F.R. § 447.253(i) (emphases added). Because HHS disapproved the proposed amendments to implement the rate cuts, petitioners cannot

currently pay for services using any rates but the unreduced rates previously approved by the federal government. *See Oregon Ass'n of Homes for Aging, Inc. v. Oregon*, 5 F.3d 1239, 1241 (9th Cir. 1993) ("A [state] law that effects a change in payment methods or standards without HCFA approval is invalid."); *Temple Univ. v. White,* 941 F.2d 201, 214 (3d Cir. 1991) ("Without an approved State plan, there can be no approved rates and, therefore, no payments available to be made by [the State] to the hospitals."), cert. denied, 502 U.S. 1032 (1992); *Forbes Health Sys. v. Harris*, 661 F.2d 282, 286 (3d Cir. 1981) (amended state regulation "makes a change in the state reimbursement scheme which is of 'sufficient substance' to warrant HHS review prior to becoming effective"). That is so without regard to the preliminary injunctions entered in these cases.

Petitioners further assert (Supp. Br. 6) that the rate cut in one of the four separate appeals that petitioners combined into this single petition (*Dominguez*) is not affected by the disapproval of the SPAs. That particular cut, however, has been subject to intervening state legislative action that bars its implementation until at least July 1, 2012. *See* Cal. Welf. & Inst. Code § 12306.1(d)(7)(B) (signed by Governor on Oct. 19, 2010). Even after that date, the rate cut would take effect "only * * * if a court of competent jurisdiction has issued an order, that is not subject to appeal or for which the time to appeal has expired, upholding its validity." *Ibid.* In their action, the *Dominguez* respondents have also challenged the

validity of the rate cuts under the Americans with Disabilities Act and Rehabilitation Act, and those claims are still pending in the district court. Thus, the State cannot implement that rate cut until at least July 1, 2012, and until after a final disposition resolving *all* challenges to the validity of that rate cut, including challenges that are not affected at all by the issues raised in the petition.

Accordingly, because of subsequent HHS and state legislative action, the preliminary injunctions are not presently a but-for cause of the State not being able to implement any of the challenged rate cuts. Setting aside those injunctions would not allow implementation of the rate cuts, and review on an incomplete record is unwarranted at this time.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted,

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Petitioners,

v.

CALIFORNIA PHARMACISTS ASSOCIATION, et al.,

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H.R. Rep. No. 105-149 (1997) 1

Petitioners submit this supplemental brief in response to the Joint Supplemental Brief of Respondents California Pharmacists Association, et al., Independent Living Center of Southern California, et al., and Lydia Dominguez, et al.

SUPPLEMENTAL REASONS FOR GRANTING THE PETITION

Respondents cite a regulation, 42 C.F.R. § 447.253(i), for the proposition that federal approval is required before a state may implement a Medicaid rate reduction. However, § 447.253 does not contain an express pre-approval requirement; it was promulgated to implement the Boren Amendment (former 42 U.S.C. § 1396a(a)(13)(A)), which has since been repealed, not 42 U.S.C. § 1396a(a)(30)(A); and the United States Department of Health and Human Services (HHS) has confirmed that states are not required to comply with the Boren-era requirements implemented by this regulation. Supp. App. 1. Unlike § 1396a(a)(30)(A), Boren expressly required states to "find[], and make[] assurances satisfactory to the Secretary" that their rates were "reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities." *Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 502-03 (1990). In repealing Boren, Congress sought to increase states' flexibility in managing their Medicaid programs and in implementing cost savings. H.R. Rep. No. 105-149, at 590-91 (1997); *Evergreen Presbyterian*

Ministries Inc. v. Hood, 235 F.3d 908, 919 n.12 (5th Cir. 2000).[1]

The Third and Ninth Circuit cases cited by respondents are similarly inapposite. They, too, solely concerned states' obligations under the Boren Amendment. Respondents cite *Oregon Association of Homes for the Aging v. Oregon*, 5 F.3d 1239 (9th Cir. 1993), but not the Ninth Circuit's later decision, *Exeter Memorial Hospital Association v. Belshe*, 145 F.3d 1106, 1109 (9th Cir. 1998), which recognized that the outcome could be different following repeal of Boren. Even as to the Boren Amendment, with its more rigorous federal approval requirements, the circuits were not unanimous in their interpretations. *See Wis. Hosp. Ass'n v. Reivitz*, 733 F.2d 1226, 1237 (7th Cir. 1984) ("[T]he omission of this requirement [from the statute], when considered in connection with Congress' previously noted statements that it intended to give the states greater flexibility and freedom from extensive federal oversight, suggests that *proposed amendments may be implemented before approval is received from HHS*." (emphasis added)).

Respondents already made this argument regarding the need for HHS pre-approval in opposing

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[1] Even were it in effect and relevant, § 447.253 would not apply to the state statute at issue in the *Dominguez* decision, which does not effectuate a rate reduction, but only a reduction in the State's contribution to rates set by the counties pursuant to collective bargaining with provider unions. *See* Pet. App. 59, 65-66.

the petition for certiorari,[2] and the Solicitor General declined to address or endorse it in his invitation brief. The sudden, recent decision of the Centers for Medicare and Medicaid Services to disapprove all of the long-pending State Plan Amendments (SPAs) at issue here and in the two other petitions for certiorari, largely for reasons having nothing to do with their merits, does not change the analysis, as there has been no final agency action concerning any of the SPAs at issue. Once the pending administrative appeals are concluded, some or all of the SPAs undoubtedly will be approved, and that approval may be retroactive to the quarter in which the SPAs were filed. 42 C.F.R. § 447.256(c). That should conclude the matter, but it will not, because California has been compelled by court injunctions during the interim period to pay rates in excess of the rates for which it is seeking federal approval.

The Ninth Circuit rulings in these cases have had, and continue to have, a devastating effect on California's fisc – and are based on an interpretation of the Medicaid Act that the United States agrees is erroneous. The Court should grant the petition.

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[2] Brief of Respondents California Pharmacists Association, et al., in Opposition at 2, *Maxwell-Jolly v. California Pharmacists Association, et al.*, No. 09-1158 (S. Ct. May 27, 2010); *see also* Brief of Respondents Sacramento Family Medical Clinics, Inc., et al., in Opposition at 2, *Maxwell-Jolly v. Independent Living Center of S. Cal.*, No. 09-958 (S. Ct. Apr. 19, 2010).

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Dear Mr. Pierson:

You have requested additional confirmation of the Boren Repeal guidance issued in the Health Care Financing Administration (HCFA's) December 10, 1997 letter to State Medicaid Directors. Specifically, you are seeking confirmation that States are no longer required to a) make findings and provide assurances that their payment rates are reasonable and adequate to meet the costs that must be incurred by efficiently and economically operated institutional providers and b) submit information related to these assurances.

HCFA's policy with respect to the need for findings, assurances and related information is unchanged from that reflected in the December 10, 1997 letter. Effective October 1, 1997, section 4711 of the Balanced Budget Act of 1997 repealed the Boren amendment requirements previously contained in sections 1902(a)(13) of the Social Security Act. Once repealed, the statutory basis for those requirements derived

from the Boren Amendment were superseded by the new public process requirements set out in section 4711. Included among those now superseded requirements are those reflected in Federal regulations at 42 CFR §§ 447.253 and 447.255. Therefore, HCFA advised States that they were no longer required to comply with the findings and assurances requirements, or those governing related information, contained in these provisions for plan amendments effective on or after October 1, 1997.

A Notice of Proposed Rulemaking amending the Medicaid regulations that deal with payment for the services of hospitals and long-term care facilities that would conform them to section 4711 of the Balanced Budget Act of 1997, is currently in the clearance process within the Department of Health and Human Services. We expect this publication to reflect the guidance we have been giving States and others since the enactment of section 4711. We are hopeful this proposed rule will be published soon.

I hope this letter is of assistance in conveying HCFA's position with respect to the elimination of Boren-related requirements.

Sincerely,

/s/ Debbie I. Chang

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Nos. 09-958, 09-1158 and 10-283

In the Supreme Court of the United States

TOBY DOUGLAS, DIRECTOR,
CALIFORNIA DEPARTMENT OF HEALTH CARE
SERVICES, PETITIONER

v.

INDEPENDENT LIVING CENTER OF SOUTHERN
CALIFORNIA, INC., ET AL.

TOBY DOUGLAS, DIRECTOR,
CALIFORNIA DEPARTMENT OF HEALTH CARE
SERVICES, PETITIONER

v.

CALIFORNIA PHARMACISTS ASSOCIATION, ET AL.

TOBY DOUGLAS, DIRECTOR,
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SERVICES, PETITIONER

v.

SANTA ROSA MEMORIAL HOSPITAL, ET AL.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

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QUESTION PRESENTED

Under 42 U.S.C. 1396a(a)(30)(A), a State's plan for medical assistance under the Medicaid Act must "provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan * * * as may be necessary * * * to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." The question presented is as follows:

Whether Medicaid providers and beneficiaries may maintain a cause of action under the Supremacy Clause to enforce Section 1396a(a)(30)(A) by asserting that the provision preempts state law reducing reimbursement rates.

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In the Supreme Court of the United States

No. 09-958

TOBY DOUGLAS, DIRECTOR,
CALIFORNIA DEPARTMENT OF HEALTH CARE
SERVICES, PETITIONER
v.
INDEPENDENT LIVING CENTER OF SOUTHERN
CALIFORNIA, INC., ET AL.

No. 09-1158

TOBY DOUGLAS, DIRECTOR,
CALIFORNIA DEPARTMENT OF HEALTH CARE
SERVICES, PETITIONER
v.
CALIFORNIA PHARMACISTS ASSOCIATION, ET AL.

No. 10-283

TOBY DOUGLAS, DIRECTOR,
CALIFORNIA DEPARTMENT OF HEALTH CARE
SERVICES, PETITIONER
v.
SANTA ROSA MEMORIAL HOSPITAL, ET AL.

ON WRIT OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

BRIEF FOR THE UNITED STATES
AS AMICUS CURIAE SUPPORTING PETITIONER

INTEREST OF THE UNITED STATES

These cases concern whether Medicaid providers and beneficiaries can assert a federal cause of action directly under the Supremacy Clause to enjoin state Medicaid reimbursement rates as inconsistent with Section 1396a(a)(30)(A) of the Medicaid Act. At the Court's invitation, the Acting Solicitor General filed an amicus brief on behalf of the United States at the petition stage in No. 09-958.

STATEMENT

1. The Medicaid program, established in 1965 by Title XIX of the Social Security Act (SSA), 42 U.S.C. 1396 *et seq.*, is a cooperative federal-state program to provide medical care to needy individuals. *Wilder* v. *Virginia Hosp. Ass'n*, 496 U.S. 498, 502 (1990); *Atkins* v. *Rivera*, 477 U.S. 154, 156 (1986). State participation in Medicaid is voluntary, but those States that elect to participate must comply with requirements imposed by the Medicaid Act and by the Secretary of Health and Human Services (HHS) in her administration of the Act. *Wilder*, 496 U.S. at 502; *Rivera*, 477 U.S. at 157. Within those limits, however, each State enjoys great flexibility in both designing and administering its own program. *Alexander* v. *Choate*, 469 U.S. 287, 303 (1985).

To qualify for federal funds, participating States must submit to the Secretary, and receive approval of, a "plan for medical assistance" detailing the nature and scope of the State's Medicaid program. 42 U.S.C. 1396a(a); 42 C.F.R. 430.10; *Wilder*, 496 U.S. at 502. Among other requirements, a State's plan must

> provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan * * * as may be necessary

> to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

42 U.S.C. 1396a(a)(30)(A). The Secretary reviews the State's plan (and any amendments thereto) and determines whether it complies with the statutory and regulatory requirements. 42 U.S.C. 1316(a)(1) and (b), 1396a(b); 42 C.F.R. 430.10 *et seq.* If the Secretary disapproves the plan, the State can seek reconsideration and, ultimately, judicial review in the court of appeals. See 42 U.S.C. 1316(a)(2)-(5) and (b); 42 C.F.R. 430.18, 430.38, 430.60 *et seq.* If the State does not act in compliance with an approved plan, the Secretary may initiate a compliance action and withhold federal funds. See 42 U.S.C. 1396c; 42 C.F.R. 430.35.

2. The consolidated cases challenge several reductions in Medicaid payment rates previously adopted by the California Legislature:

Assembly Bill 5 (AB 5) (09-1158 Pet. App. 190-197): On February 16, 2008, the California Legislature passed AB 5, which reduced by ten percent payments under California's Medicaid program (Medi-Cal) to physicians, dentists, pharmacies, adult day health centers (ADHCs), clinics, health systems, and other providers, and similarly reduced payments for inpatient services provided by acute care hospitals not under contract with the State (non-contract hospitals). The reductions were scheduled to take effect on July 1, 2008. 09-958 Pet. App. 4.

Assembly Bill 1183 (AB 1183) (09-1158 Pet. App. 198-217): On September 30, 2008, California adopted AB 1183, which provided that the rate reductions established by AB 5 would expire on February 28, 2009. 09-958 Pet. App. 44. AB 1183 replaced the prior ten-percent rate reductions with a one-percent reduction, except that it applied a five-percent reduction to ADHCs, pharmacies, and hospital-based nursing-facility and subacute-care services, and continued to impose a ten-percent reduction for inpatient services provided by certain non-contract hospitals. *Id.* at 44, 189. The AB 1183 reductions were scheduled to take effect on March 1, 2009. *Id.* at 189. Those reductions have generally been superseded by subsequent legislation. See Pet. Br. 9 n.3.

Senate Bill 6 (SB 6) (09-1158 Pet. App. 218-227): In February 2009, California passed SB 6, which reduced a cap on the State's maximum contribution to wages and benefits paid to employees by counties for In-Home Supportive Services (IHSS). *Id.* at 65. That reduction was scheduled to take effect on July 1, 2009, but the California Legislature passed a superseding bill that delays implementation until July 2012 and requires a court to validate the reduction prior to implementation. See Cal. Welf. & Inst. Code § 12306.1(d)(6)-(7) (West Supp. 2011).

3. The consolidated certiorari petitions encompass five lawsuits that produced several district court and court of appeals opinions—all of which ultimately resulted in a court order preliminarily enjoining the challenged rate reductions as inconsistent with Section 1396a(a)(30)(A).

a. Respondents in No. 09-958 (*Indep. Living*)—a group of pharmacies, health care providers, senior citi-

zen groups, and individual Medi-Cal beneficiaries—filed a petition in state court for a writ of mandamus seeking to enjoin petitioner from implementing certain provisions of AB 5, and alleging that the rate reductions are inconsistent with the requirements of 42 U.S.C. 1396a(a)(30)(A) and are on that basis preempted. 09-958 Pet. App. 3-5. Petitioner removed the suit to federal court, and respondents moved for a preliminary injunction, which the district court denied. *Id.* at 5-6. Following circuit precedent, the district court explained that Section 1396a(a)(30)(A) does not confer individual rights enforceable under 42 U.S.C. 1983. No. 08-3315, 2008 WL 4298223, at *3 (C.D. Cal. June 25, 2008). The court then held that respondents did not have an implied right of action to pursue their preemption claim under the Supremacy Clause. *Id.* at *4-*5.

The court of appeals reversed. 09-958 Pet. App. 58-93. The court explained that "[t]he Supreme Court has repeatedly entertained claims for injunctive relief based on federal preemption, without requiring that the standards for bringing suit under [Section] 1983 be met." *Id.* at 68. The court continued: "For more than a century, federal courts have entertained suits seeking to enjoin state officials from implementing state legislation allegedly preempted by federal law." *Id.* at 83. Seeing "no reason to depart from the general rule in this case, or in this category of cases," the court held "that a party may seek injunctive relief under the Supremacy Clause regardless of whether the federal statute at issue confers any substantive rights on would-be plaintiffs." *Ibid.* This Court denied certiorari. 129 S. Ct. 2828 (2009).

On remand, the district court granted a preliminary injunction in relevant part. 09-958 Pet. App. 94-124. The court later clarified that its injunction applied only

prospectively, to payments made for services provided on or after the date on which the preliminary injunction was entered. *Id.* at 125-126, 128-129 n.1. The court of appeals affirmed the district court's order granting a preliminary injunction, but reversed the subsequent order granting only prospective relief. *Id.* at 1-38, 54-57.[1]

b. The petition in No. 09-1158 (*Cal. Pharm.*) encompasses three cases:

In *Independent Living Center* v. *Maxwell-Jolly*, No. 09-382 (C.D. Cal.) (*Independent Living*), a group of pharmacies, pharmacists, and other health care providers filed suit in federal court seeking an injunction to prevent petitioner from implementing the five-percent rate reduction for pharmacy services imposed by AB 1183, and alleging that it is inconsistent with the requirements of Section 1396a(a)(30)(A) and thus preempted. 09-1158 Pet. App. 53-54, 128-130, 133. The district court granted a preliminary injunction, and the court of appeals affirmed. *Id.* at 53-58, 128-151.

In *California Pharmacists Ass'n* v. *Maxwell-Jolly*, No. 09-722 (C.D. Cal.) (*California Pharmacists*), a group of ADHCs, hospitals, pharmacies, and Medi-Cal beneficiaries filed suit in federal court seeking an injunction to prevent petitioner from implementing certain five-percent rate reductions imposed by AB 1183, because, they allege, those reductions are inconsistent with Section 1396a(a)(30)(A). 09-1158 Pet. App. 84-87, 95-96, 106-108, 111-112. The district court preliminarily enjoined the rate reduction for ADHCs, but declined to enjoin the reduction for certain hospital services be-

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[1] Petitioner did not challenge the retroactive-payments holding in its petition. 09-958 Pet. 11 n.4.

cause, the court found, respondents had not demonstrated irreparable harm. *Id.* at 104, 126-127.[2]

The court of appeals affirmed in part, but held that the district court abused its discretion in denying a preliminary injunction with respect to the hospital-service rate reductions. 09-1158 Pet. App. 1-41. The court of appeals reasoned that "a finding of irreparable harm does not turn on 'whether the plaintiffs asserting the economic injury were in any sense intended beneficiaries of the federal statute on which the Supremacy Clause cause of action was premised.'" *Id.* at 38-39 (citation omitted); see *id.* at 46-48. Rather, the court continued, a "cause of action based on the Supremacy Clause obviates the need for reliance on third-party rights" and, therefore, respondents "could enforce the structural relationship between the federal and state governments so long as they had Article III standing as, essentially, private enforcers of the Supremacy Clause." *Id.* at 39 (citation omitted).

In *Dominguez* v. *Schwarzenegger*, No. 09-2306 (N.D. Cal.), recipients of services under the IHSS program and unions representing IHSS providers filed a putative class action in federal court seeking to enjoin petitioner from implementing the SB 6 cap on contributions to IHSS providers because, they alleged, it is preempted by Section 1396a(a)(30)(A). 09-1158 Pet. App. 61. The district court certified a class of IHSS consumers in certain counties and granted a preliminary injunction. *Id.* at 161-175; *Dominguez* v. *Schwarzenegger*, 270 F.R.D. 477 (N.D. Cal. 2010). The court of appeals affirmed. 09-1158 Pet. App. 59-83.

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[2] Because the district court had already enjoined the pharmacy rate reductions in *Independent Living*, it considered that request moot. 09-1158 Pet. App. 86-87.

c. Respondents in No. 10-283 (*Santa Rosa*), all non-contract hospitals, filed suit in federal court seeking an injunction to prevent petitioner from implementing the ten-percent rate reduction for non-contract hospitals imposed by AB 5, because, they allege, it is inconsistent with, and preempted by, Section 1396a(a)(30)(A).[3] 10-283 Pet. App. 10-13. The district court granted a preliminary injunction and the court of appeals affirmed. *Id.* at 1-4, 24.

4. In September and December 2008, the State submitted to HHS for approval State Plan Amendments (SPAs) for the rate reductions encompassed in AB 5 and AB 1183. On November 18, 2010, HHS disapproved the SPAs. No. 09-958 Gov't Pet. Br. App. 1a-4a. The disapproval letter explained that HHS could not approve the amendments because, among other things, "California has not demonstrated that it would meet the conditions set out in" Section 1396a(a)(30)(A), *id.* at 2a, specifically the condition "that State plans assure that 'payments [to providers] . . . are sufficient to enlist enough providers so that care and services are available under the [State's Medicaid] plan [to recipients] at least to the extent that such care and services are available to the general population in the geographic area,'" *ibid.* (quoting 42 U.S.C. 1396a(a)(30)(A)) (brackets in original). The State requested reconsideration of the disapproval, *id.* at 5a-7a, which triggered a formal administrative hearing process, see p. 3, *supra*. Several of the respondents in these cases have been granted leave to file briefs as amici curiae in the administrative proceeding. Pet. Br. 8 n.2.

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[3] Respondents had initially also sought to enjoin the ten-percent rate reduction imposed on non-contract hospital services by AB 1183, but, while the case was pending, that reduction was stayed by the Ninth Circuit in *California Pharmacists*. 10-283 Pet. App. 11 n.2.

SUMMARY OF ARGUMENT

1. Respondents do not dispute that there is no statutory private right of action to enforce 42 U.S.C. 1396a(a)(30)(A), either under 42 U.S.C. 1983 or directly under the Medicaid Act. Section 1396a(a)(30)(A) does not itself create an individual entitlement to a certain level of payments or to covered services that would be enforceable under this Court's decision in *Gonzaga University* v. *Doe*, 536 U.S. 273 (2002). It instead provides broad criteria to guide HHS's determinations regarding the adequacy of the methods and procedures set out in a State's Medicaid plan.

2. This Court has never squarely decided if or when a private party has a cause of action to enjoin operation of state law as preempted by a federal statute that itself contains no private right of action and that does not confer individual rights enforceable under Section 1983. The Court has, however, decided dozens of preemption claims against state officials on their merits in cases brought in federal court, perhaps implicitly assuming that some federal cause of action exists in some circumstances. Although the Court has not explored the nature or source of the cause of action, its cases reflect a longstanding practice of permitting private parties to bring suit in federal court to enjoin state regulatory action from which the plaintiffs claim immunity under federal law.

The present cases do not require the Court either to reexamine that practice or otherwise attempt to catalog the range of circumstances under which a nonstatutory cause of action may be available to enjoin state officials from violating federal law. Respondents' claims differ from those in the Court's previous cases in at least two relevant respects. First, unlike the vast majority of the

cases in which this Court has entertained suits to enjoin state law as preempted by federal law, the present cases concern allegedly preempted state laws (*i.e.*, the State's challenged rate reductions) that are carried out as part of the State's implementation of the allegedly preemptive federal law (*i.e.*, Medicaid), a joint federal-state program enacted by Congress as part of the SSA, pursuant to Congress's powers under the Spending Clause. And second, respondents face no affirmative enforcement action by the State in which federal preemption would have been a defense at law, nor do they seek immunity from allegedly preempted state regulation that the State seeks to impose on them.

3. Assuming a nonstatutory cause of action is available in certain circumstances to vindicate the supremacy of federal law, the relevant features of the statutory scheme counsel against recognizing a nonstatutory cause of action for Medicaid providers and beneficiaries to enforce Section 1396a(a)(30)(A).

Section 1396a(a)(30)(A) differs from many other provisions of federal law in that it is part of a cooperative federal-state program enacted pursuant to Congress's Spending Clause authority. In creating such a program, Congress may vest the administering federal agency with exclusive responsibility for ensuring the State's compliance with particular provisions, or it may choose to supplement agency enforcement with private judicial enforcement. Here, Congress has not provided for private enforcement, either in a right of action under the statute itself or under 42 U.S.C. 1983; recognition of a nonstatutory private right of action would be inconsistent with the nature of the federal-state relationship in this setting. The Medicaid program operates in a manner similar in some respects to a contract between the

federal government and the State. As a general rule, third-party beneficiaries to a contract have no right to sue for enforcement unless they are the intended, rather than incidental, beneficiaries of the contract, such that they were intended to have a right to sue. In light of Congress's decision not to provide a right of action, this parallel counsels against recognizing a nonstatutory private right of action in this case.

With respect to federal-state cooperative programs under the SSA, the Court's cases and subsequent enactments reinforce that conclusion. Whereas the Court has assumed the existence of a nonstatutory cause of action in some circumstances, both the Court and Congress have assumed that no such cause of action exists to enforce the terms of federal-state programs under the SSA. That understanding is reflected in amendments to the SSA enacted by Congress in 1994.

Finally, regardless of whether it would be invoked in a Section 1983 suit or an injunctive action of the sort the court of appeals authorized here, the language of Section 1396a(a)(30)(A) itself provides little guidance to courts about how to apply and balance the general, and sometimes competing, policy objectives outlined in the provision. The language of Section 1396a(a)(30)(A) therefore calls for interpretation and evaluation by the responsible agency, rather than private judicial enforcement.

ARGUMENT

MEDICAID PROVIDERS AND BENEFICIARIES CANNOT MAINTAIN A CAUSE OF ACTION FOR EQUITABLE RELIEF TO ENFORCE 42 U.S.C. 1396a(a)(30)(A) AGAINST STATE OFFICIALS

The Department of Health and Human Services is committed to ensuring that State Medicaid programs

afford beneficiaries meaningful access to covered care and services. It is essential under 42 U.S.C. 1396a(a)(30)(A) that States carefully consider what impact payment rate changes may have on the availability of providers sufficient to furnish covered care and services to Medicaid beneficiaries. To that end, HHS recently promulgated a proposed rule to "create a standardized, transparent process for States to follow as part of their broader efforts to" comply with Section 1396a(a)(30)(A). 76 Fed. Reg. 26,342 (2011).

The question in these cases, however, does not concern the States' substantive obligations under Section 1396a(a)(30)(A), but whether Medicaid providers and beneficiaries have a right of action to sue state officials to enjoin the operation of state law that is assertedly not in compliance with Section 1396a(a)(30)(A). As we explain below, given the features of that provision and the statutory scheme in which it appears, no such private right of action is available.

A. No Federal Statute Provides A Private Cause Of Action To Enforce 42 U.S.C. 1396a(a)(30)(A) Against State Officials

Respondents do not assert a private right of action to enforce violations of 42 U.S.C. 1396a(a)(30)(A) under 42 U.S.C. 1983 or directly under the Medicaid Act. Nor have they disputed that no such statutory cause of action exists under this Court's precedents.

1. To seek redress under 42 U.S.C. 1983, "a plaintiff must assert the violation of a federal *right*, not merely a violation of federal *law*." *Blessing* v. *Freestone*, 520 U.S. 329, 340 (1997). In *Blessing*, the Court set forth three "factors" for courts to consider in deciding whether a statute confers a right enforceable under

42 U.S.C. 1983: (1) whether Congress "intended that the provision in question benefit the plaintiff," (2) whether "the right assertedly protected by the statute is" "so 'vague and amorphous' that its enforcement would strain judicial competence," and (3) whether the provision is "couched in mandatory, rather than precatory, terms." 520 U.S. at 340-341 (citations omitted). In *Gonzaga University* v. *Doe*, 536 U.S. 273, 283 (2002), the Court clarified that "anything short of an unambiguously conferred right" could not "support a cause of action brought under" 42 U.S.C. 1983, and emphasized that only "*rights*, not the broader or vaguer 'benefits' or 'interests,' * * * may be enforced under the authority of that section." *Ibid.*

After *Gonzaga*, nearly every court of appeals to consider the issue, including the Ninth Circuit, has correctly held that 42 U.S.C. 1396a(a)(30)(A) does not confer on Medicaid providers or beneficiaries individual private rights enforceable under 42 U.S.C. 1983. See *Equal Access for El Paso, Inc.* v. *Hawkins*, 509 F.3d 697, 703-704 (5th Cir. 2007) (providers and beneficiaries), cert. denied, 129 S. Ct. 34 (2008); *Mandy R.* v. *Owens*, 464 F.3d 1139, 1147-1148 (10th Cir. 2006) (providers and beneficiaries), cert. denied, 549 U.S. 1305 (2007); *Westside Mothers* v. *Olszewski*, 454 F.3d 532, 542-543 (6th Cir. 2006) (providers and beneficiaries); *New York Ass'n of Homes & Servs. for the Aging* v. *DeBuono*, 444 F.3d 147, 148 (2d Cir. 2006) (per curiam) (providers); *Sanchez* v. *Johnson*, 416 F.3d 1051, 1058-1062 (9th Cir. 2005) (providers and beneficiaries); *Long Term Care Pharmacy Alliance* v. *Ferguson*, 362 F.3d 50, 58-59 (1st Cir. 2004) (providers). But see *Pediatric Specialty Care, Inc.* v. *Arkansas Dep't of Human Servs.*, 443 F.3d 1005, 1016 (8th Cir. 2006) (declining to recon-

sider prior circuit precedent holding that Section 1396a(a)(30)(A) is enforceable by providers and beneficiaries through Section 1983), cert. granted, judgment vacated in part, 551 U.S. 1142 (2007) (mem.).[4]

As the courts of appeals have concluded, Section 1396a(a)(30)(A) does not contain "the sort of 'rights-creating' language critical to showing the requisite congressional intent to create new rights." *Gonzaga*, 536 U.S. at 287 (citation omitted). Section 1396a(a)(30)(A) provides that "methods and procedures" must be included in State plans "relating to" utilization and payment to assure that payments are "consistent with efficiency, economy, and quality of care" and are "sufficient to enlist enough providers so that care and services are available" to the extent that they "are available to the general population in the geographic area." 42 U.S.C. 1396a(a)(30)(A). That provision is directed at the "overall methodology" of the State plan. *Sanchez*, 416 F.3d at 1059. It makes no express mention of individual Medicaid beneficiaries and it speaks of Medicaid providers not as rights holders but as being "'enlisted' as subordinate partners in the administration of Medicaid services." *Ibid.* Like the "substantial compliance" provision at

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[4] In *Wilder* v. *Virginia Hospital Ass'n*, 496 U.S. 498 (1990), this Court held that the Boren Amendment, which required States to make payments based on rates that "are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities" providing inpatient hospital, skilled nursing, and other institutional services (42 U.S.C. 1396a(a)(13)(A) (1988)), created a right enforceable by Medicaid providers under Section 1983. In the Balanced Budget Act of 1997, Congress repealed the Boren Amendment and replaced it with a more limited requirement that States provide for public notice-and-comment participation in their ratemaking processes for such institutional services. Pub. L. No. 105-33, § 4711, 111 Stat. 507-508 (42 U.S.C. 1396a(a)(13)(A)).

issue in *Blessing*, Section 1396a(a)(30)(A), on its own, is a "yardstick" for designing and evaluating "*systemwide* performance" based on "the aggregate services provided by the State." 520 U.S. at 343 (concluding that "the requirement that a State operate its child support program in 'substantial compliance' with Title IV-D [of the SSA] was not intended to benefit individual children and custodial parents"). Section 1396a(a)(30)(A) thus does not itself unambiguously create an "*individual* entitlement to services." *Ibid.*

As the courts of appeals have also concluded, the language of Section 1396a(a)(30)(A) is "broad and nonspecific." *Long Term Care Pharmacy Alliance*, 362 F.3d at 58 (quoting *Gonzaga*, 536 U.S. at 292 (Breyer, J., concurring in the judgment)); accord *Sanchez*, 416 F.3d at 1060. Neither the Act nor any regulations promulgated by the Secretary identify a standard by which these broad policy objectives—"efficiency," "economy," "quality of care," and "enlist[ing]" enough providers to make care and services "available * * * at least to the extent that such care and services are available to the general population in the geographic area," 42 U.S.C. 1396a(a)(30)(A)—are to be measured. Cf. *Blessing*, 520 U.S. at 340-341 (stating that enforcement of "vague and amorphous" provision "would strain judicial competence") (citation omitted); Gov't Br. at 15, *Belshe* v. *Orthopaedic Hosp.*, No. 96-1742 (Nov. 26, 1997) (making similar argument regarding "efficiency, economy, and quality of care"). Nor do they give any guidance as to how a court should balance such general, and sometimes competing, policy objectives.[5] See *Sanchez*, 416 F.3d at

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[5] The proposed rule recently promulgated by the Secretary does not provide "nationwide standards" or adopt a "singular approach" to com-

1059-1060. The inquiry necessarily turns on determinations and predictions of legislative fact of the sort appropriate for expert judgment by the State and then by HHS. Interpretation and weighing of these objectives in private Section 1983 suits would require the courts to make policy judgments in the first instance and would not provide the opportunity for broader public input often associated with agency decisionmaking. Cf. *Gonzaga*, 536 U.S. at 292 (Breyer, J., concurring in the judgment).

2. It is also undisputed that the Medicaid Act itself affords providers and beneficiaries no statutory cause of action to enforce Section 1396a(a)(30)(A) against noncompliant States. See *Maine* v. *Thiboutot*, 448 U.S. 1, 6 (1980) (stating that the SSA, of which the Medicaid Act is a part, "affords no private right of action against a State"). "[W]here the text and structure of a statute provide no indication that Congress intends to create new individual rights," as is the case here, "there is no basis for a private suit, whether under [Section] 1983 or under an implied right of action." *Gonzaga*, 536 U.S. at 286; see *Suter* v. *Artist M.*, 503 U.S. 347, 363-364 (1992).

B. This Court Has Never Squarely Decided If Or When A Nonstatutory Cause Of Action For Equitable Relief On Preemption Grounds Should Be Recognized Under The Supremacy Clause Or Otherwise

The Court need not decide in these cases if or when a private party can bring a federal nonstatutory cause of action for equitable relief against state officials on preemption grounds as a general matter. These cases are

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pliance, 76 Fed. Reg. at 26,344, but instead requires States to develop data on access to services to facilitate compliance determinations by the State and HHS, *id.* at 26,349.

unlike the vast majority of preemption claims the Court has entertained to date, because they arise under a cooperative federal-state program under the SSA, enacted pursuant to Congress's powers under the Spending Clause. As explained in Part C, *infra*, the Court should resolve the question presented based on the particular features of that statutory scheme.

1. This Court has never squarely decided if or when a cause of action for equitable relief should be recognized directly under the Supremacy Clause, in the absence of a federal statutory cause of action. The Court has held that "[a] plaintiff who seeks injunctive relief from state regulation, on the ground that such regulation is pre-empted by a federal statute which, by virtue of the Supremacy Clause of the Constitution, must prevail, * * * presents a federal question which the federal courts have jurisdiction under 28 U.S.C. [] 1331 to resolve." *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 96 n.14 (1983). But the question at issue in *Shaw*, of subject matter jurisdiction, is analytically distinct from the question whether the Court should recognize a private right of action directly under the Supremacy Clause to seek injunctive relief against implementation of state law that allegedly conflicts with federal law. See *Verizon Md. Inc.* v. *Public Serv. Comm'n*, 535 U.S. 635, 642-643 (2002) ("It is firmly established in our cases that the absence of a valid (as opposed to arguable) cause of action does not implicate subject-matter jurisdiction, *i.e.*, the courts' statutory or constitutional *power* to adjudicate the case.") (quoting *Steel Co.* v. *Citizens for a Better Env't*, 523 U.S. 83, 89 (1998)); see *id.* at 642 (not deciding whether there was a private cause of action).

The Court has, however, decided dozens of preemption claims against state officials on their merits in cases

brought in federal court, perhaps implicitly assuming that some federal cause of action exists in some circumstances. See, *e.g.*, *Rowe* v. *New Hampshire Motor Transp. Ass'n*, 552 U.S. 364 (2008); *Watters* v. *Wachovia Bank, N.A.*, 550 U.S. 1 (2007); *Arkansas Dep't of Health & Human Servs.* v. *Ahlborn*, 547 U.S. 268 (2006); *American Ins. Ass'n* v. *Garamendi*, 539 U.S. 396 (2003); *PhRMA* v. *Walsh*, 538 U.S. 644 (2003) (plurality opinion). Some Members of the Court have expressed approval in some contexts of a federal cause of action to prevent enforcement against plaintiffs of an allegedly preempted state law in the absence of a right under Section 1983. See, *e.g.*, *Golden State Transit Corp.* v. *City of L.A.*, 493 U.S. 103, 119 (1989) (Kennedy, J., dissenting) (plaintiffs may pursue preemption claim "by seeking declaratory and equitable relief in the federal district courts through their powers under federal jurisdictional statutes," because "[t]hese statutes do not limit jurisdiction to those who can show the deprivation of a right, privilege, or immunity secured by federal law within the meaning of [Section] 1983") (citing 28 U.S.C. 1331, 2201, 2202). Others have raised doubts about the existence of a nonstatutory private cause of action in certain contexts. See, *e.g.*, *PhRMA*, 538 U.S. at 683 (Thomas, J., concurring in the judgment) (noting "serious questions as to whether third parties may sue to enforce Spending Clause legislation—through pre-emption or otherwise"). The Court has never, however, directly addressed the existence, source, or scope of a nonstatutory private right of action to enjoin state officials from enforcing a state statute, regulation, or policy that allegedly conflicts with, and is thus preempted by, federal law.

2. The Court's cases do, however, reflect a long-standing practice of entertaining suits by private parties in federal court to enjoin state regulatory action to which the plaintiffs claim immunity under federal law. (Cf. *Golden State Transit*, 493 U.S. at 113 (Kennedy, J., dissenting) (The Court has long permitted "a private party [to] assert an immunity from state or local regulation on the ground that the Constitution or a federal statute, or both, allocate the power to enact the regulation to the National Government, to the exclusion of the States."). The underlying suit in *Ex parte Young*, 209 U.S. 123 (1908), is an early example. Some have described *Young* as invoking the accepted principle of equity jurisprudence that a plaintiff could bring a suit to bar an action at law against which the plaintiff in equity would have a valid defense, where the plaintiff in equity (the defendant in the prospective action at law) did not have an adequate remedy at law. See *Virginia Office for Prot. & Advocacy* v. *Stewart*, 131 S. Ct. 1632, 1643 (2011) (*VOPA*) (Kennedy, J., concurring) (describing the underlying suit in *Young* as "nothing more than the pre-emptive assertion in equity of a defense that would otherwise have been available in the State's enforcement proceedings at law," and citing John Harrison, *Ex Parte Young*, 60 Stan. L. Rev. 989, 997-999 (2008));[6] cf. 4 John Norton Pomeroy, Jr., *Equity Jur-*

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[6] The origins of the cause of action underlying this Court's decision in *Young* present a question distinct from the *Young* doctrine as it relates to a State's Eleventh Amendment immunity from suit, and the origins of the cause of action therefore do not define the outer limits of the *Young* doctrine concerning the Eleventh Amendment. Thus, the principles of Eleventh Amendment immunity established in *Young* apply both where the plaintiff's cause of action is conferred by a federal statute, such as 42 U.S.C. 1983, and where the cause of action is judi-

risprudence §§ 1360-1364 (4th ed. 1919); 1 C.L. Bates, *Federal Equity Procedure* § 540 (1901).

Although the question now before the Court asks specifically whether respondents have an implied right of action directly under the Supremacy Clause, this Court's cases suggest that may not be the only, or even the best, understanding of the source of a nonstatutory cause of action to enjoin enforcement of state action that is inconsistent with federal law. The Supremacy Clause, as this Court has often stated, is not itself a source of federal rights, but rather "'secure[s]' federal rights by according them priority whenever they come in conflict with state law." *Golden State Transit*, 493 U.S. at 107 (quoting *Chapman* v. *Houston Welfare Rights Org.*, 441 U.S. 600, 613 (1979)) (brackets in original); cf. *Swift & Co.* v. *Wickham*, 382 U.S. 111, 116-129 (1965) (challenge to a state law as preempted did not require a three-judge court under former 28 U.S.C. 2281 (1964), which required such a court whenever a statute was sought to be enjoined "upon the ground of the unconstitutionality of such statute"). The Court's practice may be better understood as rooted in the courts' historical exercise of equitable powers.[7] But whether or not that

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cially fashioned. And as the Court recently reaffirmed in *VOPA*, "[i]n determining whether the doctrine of *Ex parte Young* avoids an Eleventh Amendment bar to suit, a court need only conduct a 'straightforward inquiry into whether [the] complaint alleges an ongoing violation of federal law and seeks relief properly characterized as prospective.'" 131 S. Ct. at 1639 (quoting *Verizon Md.*, 535 U.S. at 645) (brackets in original).

[7] The Court's practice originated before the development of modern implied-cause-of-action jurisprudence. See *Bush* v. *Lucas*, 462 U.S. 367, 373 & n.10 (1983) (discussing "common-law approach to the judicial recognition of new causes of action"); *Alexander* v. *Sandoval*, 532 U.S. 275, 287 (2001) (discussing development of Court's modern jurispru-

is the correct (or only) underpinning of the Court's practice of resolving preemption cases brought in federal court on the merits, the ability of private parties to obtain protection in the face of state compulsion that violates federal law has considerable historical grounding and appropriately vindicates the supremacy of federal law.

3. To resolve the question in these cases, however, the Court need not (and should not) consider the full range of circumstances in which a suit for injunctive relief would lie based on claimed preemption of state law. There are particular reasons why recognition of a nonstatutory private right of action to enforce the federal statutory provision at issue would not be compatible with the nature of the statute, the methods for its enforcement, and the plaintiffs' claim.

These cases are distinct from the many cases in which the Court has allowed claims to proceed with the assumption that a cause of action exists. Here, while respondents frame their claims as sounding in "preemption," they use that term "in a rather special sense," since, unlike many preemption cases, these cases "do[] not involve arguable federal pre-emption of a wholly

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dence). That practice may reflect a pre-*Erie* understanding that the "general" law recognized such suits in equity. See *Wheeldin* v. *Wheeler*, 373 U.S. 647, 651 (1963) (noting federal courts' creation of common-law rights before *Erie R.R.* v. *Tompkins*, 304 U.S. 64 (1938)). Or, perhaps relatedly, it may reflect an understanding that the conferral of jurisdiction on a federal court allowed it to exercise such equitable authority in certain circumstances. See *Golden State Transit*, 493 U.S. at 119 (Kennedy, J., dissenting) (noting possibility of pursuing certain preemption claims "by seeking declaratory and equitable relief in the federal district courts through their powers under federal jurisdictional statutes"). In any event, the practice is now well established and serves an important purpose in vindicating the supremacy of federal law.

independent state program dealing with the same or a similar problem." *New York State Dep't of Social Servs.* v. *Dublino*, 413 U.S. 405, 411 n.9 (1973). Medicaid is a joint federal-state program enacted by Congress as part of the SSA, pursuant to its powers under the Spending Clause, and the State's rate reductions are carried out as part of the implementation of that program and in the context of the State's bilateral undertaking with the federal government. And, unlike the vast majority of the cases in which the Court has considered preemption claims brought in federal court on their merits, respondents face no affirmative enforcement action by the State in which federal preemption would have been a defense at law. Nor do they seek immunity from allegedly preempted state regulation that the State seeks to impose on them. The challenged Medi-Cal rate reductions do not regulate respondents' primary conduct. Rather, they offer providers less money for certain services than what allegedly should be paid under the cooperative federal-state Medicaid program—and, in turn, allegedly limit the availability of those services to beneficiaries.

4. Since *Gonzaga*, this Court has decided only one case, *PhRMA* v. *Walsh*, in which a private party sued in federal court to enjoin state officials from enforcing an allegedly preempted state law in circumstances that could arguably be described as similar to those here. The court below extensively relied on that case in reaching its conclusion that a nonstatutory cause of action is available to respondents here. See 09-958 Pet. App. 77-83. But that case differed in important respects from

these cases, and this Court's decision in any event provides little support for the decisions below.[8]

In *PhRMA*, a pharmaceutical manufacturers' association sued to enjoin a Maine program designed to obtain discounted drug prices for persons not covered by Medicaid. To encourage participation, Maine required drug companies that refused to participate in that program to submit their drugs to prior-authorization procedures under Medicaid. 538 U.S. at 649-650. The statutory (or nonstatutory) basis for the cause of action was not addressed by the Court. Cf. *id.* at 683 (Thomas, J., concurring in the judgment).[9] And, of course, the ques-

[8] The government's amicus brief at the petition stage noted that the Court's decision in *Crosby* v. *National Foreign Trade Council*, 530 U.S. 363 (2000), might not "necessarily fit [the] description" of a case in which "the plaintiff was regulated by the challenged state law and could have raised a preemption defense in any enforcement action for noncompliance." See 09-958 Gov't Pet. Br. 17-18. In *Crosby*, the plaintiff —a nonprofit corporation representing entities that did business with Burma—sought to enjoin enforcement of a state law that generally precluded state agencies from purchasing goods or services from companies that did business with Burma. 530 U.S. at 367-370. Although a company's contract ineligibility may not have been imposed through formal proceedings initiated by the State in which preemption could have been raised as a defense, the state law was an affirmative (and independent) exercise of the State's authority to impose and enforce what were essentially state regulatory standards. *Id.* at 373 n.7. Moreover, because the Constitution's allocation of foreign affairs powers to the national government was the basis for the alleged preemption, there was a particular structural foundation for a suit to enjoin the state law.

[9] In the court of appeals, and in this Court, the State did argue that PhRMA lacked prudential standing. See *PhRMA* v. *Concannon*, 249 F.3d 66, 72-73 (1st Cir. 2001), aff'd, 538 U.S. 644 (2003); Resp. Br. at *13-*17, *PhRMA*, *supra* (01-18S). The court of appeals rejected that argument, 249 F.3d at 73, but this Court did not address it, perhaps because it did not view the issue as properly presented. Cf. Reply Br.

tion whether a cause of action exists, unlike the existence of federal jurisdiction, may be assumed without being decided. See *Bucks* v. *Lasker*, 441 U.S. 471, 476 & n.5 (1979); cf. *Steel Co.*, 523 U.S. at 91 ("[D]rive-by jurisdictional rulings * * * have no precedential effect.").

However the Court might have resolved that question had it been presented, *PhRMA* arose in a different context than these cases. The question in *PhRMA* was not whether the State had complied with obligations imposed on it as a condition of receiving federal Medicaid funds, but whether the State's use of its Medicaid authority as a tool to impose on drug manufacturers an independent state rebate requirement was consistent with the Medicaid statute. Thus, unlike these cases, the state law at issue in *PhRMA* constituted an affirmative exercise of the State's authority to impose and enforce what were, in essence, state regulatory requirements directed to the pharmaceutical companies' primary conduct outside the Medicaid program—and the companies were, in effect, asserting an immunity from those regulations.

C. The Creation Of A Nonstatutory Private Cause Of Action For Equitable Relief To Enforce 42 U.S.C. 1396a(a)(30)(A) Against State Officials Would Not Be Compatible With The Nature Of The Statutory Scheme

These cases do not require the Court either to broadly determine whether and under what circumstances a nonstatutory cause of action might be available to enjoin state officials from violating federal law, or to reexamine its cases reaching the merits of preemption claims brought in federal court. Assuming a nonstatutory

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at *1 & n.1, *PhRMA*, *supra* (01-188) (arguing that the issue was not properly before the Court).

cause of action is properly available in certain circumstances to vindicate the supremacy of federal law, several considerations counsel against recognizing a nonstatutory private cause of action for Medicaid providers and beneficiaries to enforce Section 1396a(a)(30)(A).

1. First, as a general matter, Section 1396a(a)(30)(A) is a provision of a cooperative federal-state program enacted pursuant to Congress's Spending Clause authority, as to which Congress neither provided an express right of action for private parties nor conferred individually enforceable rights. Recognition of a nonstatutory cause of action for Medicaid providers and beneficiaries in this setting would be in tension with the nature of the federal-state relationship and the enforcement scheme contemplated by the statute.

a. In *Astra USA, Inc.* v. *Santa Clara County*, 131 S. Ct. 1342, 1345 (2011), the Court declined to recognize a third-party-beneficiary claim to enforce the terms of a contract between HHS and a drug company where the contractual terms were dictated by a federal-state cooperative program enacted under Congress's Spending Clause authority. There, as here, the parties did not dispute that there was no private right of action under the statutory provision at issue: the statute instead vested enforcement authority in HHS. *Id.* at 1347-1348. The Court relied in part on the fact that, in those circumstances, to allow a suit on a third-party-beneficiary rationale would have rendered meaningless the absence of a private right of action under the statute itself. *Id.* at 1348. Such a suit, the Court explained, "is in essence a suit to enforce the statute itself." *Ibid.* In those circumstances, the Court concluded, it would make "scant sense" to allow that claim to go forward "[n]o matter the clothing in which [the plaintiffs] dress their claims." *Id.*

at 1345 (quoting *Tenet* v. *Doe*, 544 U.S. 1, 8 (2005)) (first brackets in original).

Similar considerations are present here. If private parties who lack a statutory cause of action could simply style their suit as a preemption action to enjoin state officials from enforcing a state law that was adopted to implement the State's undertakings pursuant to the program, the result would be in considerable tension with Congress's decision not to confer a private right of action to enforce state compliance. In *Suter*, for example, the plaintiffs' claim that the State had not made "reasonable efforts" at family reunification in its judicial proceedings, 503 U.S. at 352, could have been re-pleaded as a claim that the State's inadequate efforts were preempted by the "reasonable efforts" provision of the Adoption Act. The State's alleged failure to abide by Title IV-D's "substantial compliance" requirements in *Blessing*, 520 U.S. at 332-333, would have been cognizable had plaintiffs instead challenged the State's program as preempted by the "substantial compliance" provision. And, in *Alexander* v. *Sandoval*, 532 U.S. 275, 279 (2001), the plaintiffs could have pursued their claim that the State's policy of offering its driving-license exam only in English violated the Department of Justice's disparate-impact regulation by the simple expedient of filing suit "under the Supremacy Clause," instead of under Title VI of the Civil Rights Act of 1964.

That most of the respondents here are seeking only injunctive relief (but see note 1, *supra*) does not mitigate the inconsistency between private judicial enforcement and the federal-state cooperative scheme that Congress created. Significantly, in all of the cases mentioned above, the plaintiffs sought only prospective relief and not damages. *E.g.*, *Suter*, 503 U.S. at 352; *Blessing*,

520 U.S. at 337; *Sandoval*, 532 U.S. at 279; see also *Wilder* v. *Virginia Hosp. Ass'n*, 496 U.S. 498, 504 & n.4 (1990).[10]

b. This Court has often said that a law enacted pursuant to the Spending Clause operates "in the nature of a contract" between the federal government and the State. *Pennhurst State Sch. & Hosp.* v. *Halderman*, 451 U.S. 1, 17 (1981); see *Arlington Cent. Sch. Dist. Bd. of Educ.* v. *Murphy*, 548 U.S. 291, 296 (2006). This Court has also recognized that neither the federal Spending Clause statute itself nor the resulting arrangement with a fund recipient constitutes an ordinary contract. See *Bennett* v. *Kentucky Dep't of Educ.*, 470 U.S. 656, 669 (1985).[11] But private parties are in a situation similar to that of third-party beneficiaries. Under traditional contract principles, third parties have judicially enforceable rights only if they are intended, rather than incidental, beneficiaries of the contract, and only if "recognition of a right to performance in the beneficiary is appropriate

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[10] Section 1983 does not provide a cause of action against States or state employees in their official capacity for damages. See *Will* v. *Michigan Dep't of State Police*, 491 U.S. 58, 71 & n.10 (1989). And, unless properly abrogated, sovereign immunity would bar retrospective damage remedies in cases asserting an implied statutory right of action against state officials acting in their official capacity. See *Quern* v. *Jordan*, 440 U.S. 332, 337-349 (1979); *Edelman* v. *Jordan*, 415 U.S. 651, 677 (1974).

[11] The Act of Congress establishing the joint federal-state program, for example, remains binding law with the full force and preemptive authority of federal legislation under the Supremacy Clause. *E.g.*, *Bennett* v. *Arkansas*, 485 U.S. 395, 397 (1988) (per curiam) (state law providing for attachment of federal benefits paid to state prisoners preempted by SSA); *Philpott* v. *Essex County Welfare Bd.*, 409 U.S. 413, 417 (1973) (state law requiring reimbursement through payment of federal disability benefits preempted by SSA).

to effectuate the intention of the parties." Restatement (Second) of Contracts § 302(1) (1981). When the contract is a government contract, "[t]he distinction between an intention to benefit a third party and an intention that the third party should have the right to enforce that intention" is vigorously enforced. 9 John E. Murray, Jr., *Corbin on Contracts* § 45.6, at 92 (rev. ed. 2007); see *German Alliance Ins. Co.* v. *Home Water Supply Co.*, 226 U.S. 220, 230-231 (1912). In light of Congress's decision not to confer individual rights under Section 1396a(a)(30)(A), see pp. 13-15, *supra*, the analogy to third-party beneficiaries counsels against creating a nonstatutory right of action to enforce Section 1396a(a)(30)(A).

2. This Court's cases and subsequent enactments reinforce the conclusion that no extra-statutory cause of action should be recognized to enforce provisions of the federal-state cooperative programs enacted as part of the SSA, including Section 1396a(a)(30)(A). In contrast to an implicit assumption that a nonstatutory private cause of action was available in the numerous preemption cases this Court has decided in other contexts (see pp. 17-21, *supra*), the shared assumption of the Court and Congress appears to have been that no such cause of action is available to challenge actions by state officials on the ground that they are allegedly inconsistent with provisions of the SSA that govern state plans under cooperative federal-state programs.

a. In *Thiboutot*, *supra*, this Court first made explicit the conclusion that the cause of action conferred by 42 U.S.C. 1983 is presumptively available not only to redress violations of the Constitution or statutes assuring equal protection, but to redress violations of all federal statutes that confer individual rights, including

statutes enacted pursuant to Congress's authority under the Spending Clause. In addition to the plain language of 42 U.S.C. 1983 (namely, the general reference to "and laws"), the Court relied heavily on its prior cases, which it read as resolving "any doubt" about the meaning of that phrase. *Thiboutot*, 448 U.S. at 4-5. In noting that several of its prior cases involving the SSA had (explicitly or implicitly) relied on the availability of a cause of action pursuant to Section 1983 for claims based on violations of federal statutes, *id.* at 4-6, the Court clearly viewed Section 1983 as the sole source of a private right of action to enforce statutory provisions governing joint federal-state programs under the SSA. As the Court explained, in all of those cases, Section 1983 "was necessarily the exclusive statutory cause of action because, as this Court held in [*Edelman* v. *Jordan*, 415 U.S. 651, 673-674 (1974)], the SSA affords no private right of action against a State." *Thiboutot*, 448 U.S. at 6. If a nonstatutory cause of action arising under the Supremacy Clause or on some other basis had been readily available, the critical premise underlying the Court's reasoning—that "any doubt" as to the meaning of "and laws" in Section 1983 had already been resolved—would have been unfounded. Each of the prior cases equally could have been explained as arising under that nonstatutory cause of action. See *ibid.* (string cite of cases seeking prospective relief from state programs alleged to be "inconsistent" with provisions of the SSA). A holding by this Court that a nonstatutory private cause of action is *also* available (and always has been) would be in considerable tension with that decision.

b. Two identical provisions of the SSA, added by Congress in 1994, similarly point to the conclusion that provisions of the SSA are privately enforceable only

when a cause of action lies under 42 U.S.C. 1983 or the provision at issue. After this Court's decision in *Suter*, Congress adopted amendments to the SSA that provide:

> In an action brought to enforce a provision of this chapter, such provision is not to be deemed unenforceable because of its inclusion in a section of this chapter requiring a State plan or specifying the required contents of a State plan. This section is not intended to limit or expand the grounds for determining the availability of private actions to enforce State plan requirements other than by overturning any such grounds applied in Suter v. Artist M., 112 S. Ct. 1360 (1992), but not applied in prior Supreme Court decisions respecting such enforceability; provided, however, that this section is not intended to alter the holding in Suter v. Artist M. that section 671(a)(15) of this title is not enforceable in a private right of action.

42 U.S.C. 1320a-2, 1320a-10. The Conference Report explained that "[t]he intent of this provision is to assure that individuals who have been injured by a State's failure to comply with the Federal mandates of the State plan titles of the [SSA] are able to seek redress in the federal courts to the extent they were able to prior to the decision in *Suter* v. *Artist M.*" H.R. Conf. Rep. No. 761, 103d Cong., 2d Sess. 926 (1994). The Report also made clear, however, that there was "no intent to overturn or reject the determination in *Suter* that the reasonable efforts clause to Title IV-E does not provide a basis for a private right of action." *Ibid.*

The amendments indicate that Congress (like the Court) was acting on the understanding that a private right of action would be available to enforce the state

plan provisions of the joint federal-state programs under the SSA only when such a cause of action is available under 42 U.S.C. 1983 (or under established implied-statutory-private-right-of-action principles). Where a cause of action is not available under either Section 1983 or the particular provision of the SSA at issue, the amendments appear to contemplate that the provision simply will not be privately enforceable.

3. Finally, Section 1396a(a)(30)(A)'s "broad and non-specific" language counsels against recognition of a nonstatutory private right of action. The terms the courts of appeals have found to be prohibitively "broad and diffuse" for purposes of Section 1983, see *Sanchez*, 416 F.3d at 1060; pp. 15-16, *supra*, would be no less so in the context of a private suit for injunctive relief brought under the Supremacy Clause or otherwise. Absent more specific guidance about how to measure a State's compliance with the general standards of economy, efficiency, quality of care, and sufficiency of payments to ensure access, such determinations are ones properly made by HHS through the exercise of its expert judgment and its bilateral relationship with the State.

As previously discussed (p. 3, *supra*), the Secretary is required to review and approve (or disapprove) the State's plan and any plan amendments to ensure compliance with Section 1396a(a)'s requirements, including Section 1396a(a)(30)(A). If the Secretary disapproves a State plan (or plan amendment), the State may seek reconsideration (as the State did here, p. 8, *supra*). And if the decision is upheld, the State may petition for judicial review in the court of appeals. Apart from the plan approval process, if the State plan does not comply with Section 1396a(a)(30)(A), the Secretary can also undertake a compliance action and withhold federal funds.

That administrative process brings to bear "the expertise, uniformity, widespread consultation, and resulting administrative guidance that can accompany agency decisionmaking." *Gonzaga*, 536 U.S. at 292 (Breyer, J., concurring in the judgment).[12]

Recognition of a nonstatutory private right of action would mean that multiple federal courts across different jurisdictions would similarly (and perhaps simultaneously) be called on to decide such compliance questions. Judicial proceedings would move forward on different evidentiary records and result in different factual findings, which would in turn be reviewable on appeal only under the "clearly erroneous" standard, Fed. R. Civ. P. 52(a)(6). And, as evidenced by the wide array of approaches the courts of appeals have taken in their interpretation of Section 1396a(a)(30)(A) (see 09-958 Gov't Pet. Br. 10-11), the proceedings would inevitably lead to the development and application of different legal standards. See *Sanchez*, 416 F.3d at 1061 (noting "that exclusive agency enforcement might fit the scheme better than a plethora of private actions threatening disparate outcomes") (internal quotation marks and citation omitted).

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[12] The United States is not suggesting that Congress has "displayed an intent not to provide the 'more complete and more immediate relief' that would otherwise be available under *Ex parte Young*." See *Verizon Md.*, 535 U.S. at 647 (quoting *Seminole Tribe* v. *Florida*, 517 U.S. 44, 75 (1996)); *VOPA*, 131 S. Ct. at 1639 n.3. Respondents are essentially asking this Court to create a federal common-law cause of action. Whether or not "these statutory provisions * * * provide a comprehensive enforcement mechanism so as to manifest Congress' intent to foreclose" private remedies, they do demonstrate that the absence of a private remedy would not render Section 1396a(a)(30)(A) a "dead letter." *Suter*, 503 U.S. at 360-361; see *Gonzaga*, 536 U.S. at 289-290.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

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In the Supreme Court of the United States

TOBY DOUGLAS, Director, California Department
of Health Care Services,
Petitioner,
v.
INDEPENDENT LIVING CENTER OF SOUTHERN
CALIFORNIA, INC., *et al.*,
Respondents.

TOBY DOUGLAS, Director, California Department
of Health Care Services,
Petitioner,
v.
CALIFORNIA PHARMACISTS ASSOCIATION, INC., *et al.*,
Respondents.

TOBY DOUGLAS, Director, California Department
of Health Care Services,
Petitioner,
v.
SANTA ROSA MEMORIAL HOSPITAL, *et al.*,
Respondents.

On Writs of Certiorari To The United States Court of Appeals For the Ninth Circuit

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Brief of *Amici Curiae* AARP, Families USA, et al.,

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INTEREST OF *AMICI CURIAE*[1]

Amici are organizations committed to serving the needs of low-income persons, including older Americans, individuals with disabilities, children, and women of child-bearing age. *Amici*'s work involves promoting public awareness of the disproportionate need for health care and barriers to care experienced by these populations and advocating for their interests and legal rights. It is in this last capacity that *amici* submit this Brief, asking the Court to affirm the decisions below.

AARP is a non-partisan, non-profit membership organization for people 50 and over. AARP advocates for health and economic security for everyone and in particular for vulnerable people of all ages, including low-income people and persons with disabilities. AARP supports access to and expansion of quality health care through publicly administered health insurance programs, including Medicaid, an essential safety net program that provides coverage to people who would otherwise be denied health care. To further that end, Medicaid recipients' access to the courts to challenge the denial of Medicaid services is critical. **Families USA** is the national, nonprofit and nonpartisan organization for health care consumers, dedicated to the achievement of high-quality, affordable health

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[1] No counsel for a party authored this brief in whole or in part or made a monetary contribution to fund the preparation or submission of this brief. No persons other than the *amici*, their members or their counsel made such a monetary contribution. The parties consented to the filing of this brief.

coverage and care for all Americans. For the past 29 years, Families USA has led various coalition efforts to protect and expand health coverage for low-income families, including the National Medicaid Coalition that it chairs.

The **National Legal Aid and Defenders Association** is the largest organization in the United States dedicated solely to securing equal justice for the disadvantaged in the civil and criminal justice systems. NLADA members represent thousands of families in need of adequate health care and access to the courts. The **National Health Law Program** is a 40-year-old public interest law firm that works to advance access to quality health care and protect the legal rights of low-income and underserved people. The **National Disability Rights Network** (NDRN) is the non-profit membership association of protection and advocacy (P&A) agencies that are located in all 50 States, the District of Columbia, Puerto Rico, and the U.S. Territories. For 30 years, P&As have worked with children and adults with disabilities who depend on Medicaid-funded services and supports to enable them to live in the community rather than in institutions. Founded in 1986, the **Center for Medicare Advocacy** is a non-profit public interest law organization that represents older and disabled people throughout the United States. The Center works to advance fair access to Medicare, Medicaid and quality health care through individual representation, education, policy analysis, administrative advocacy, and litigation.

First Focus is a bipartisan advocacy organization that is committed to making children and families a priority in federal policy and budget decisions. In all of its work, First Focus strives to ensure that every child in America has access to the high quality, comprehensive, affordable health care they need to grow up to become healthy and productive adults. For over 25 years, **Voices for America's Children**, the nation's largest network of multi-issue child advocacy organizations, has directly advocated for full implementation of the Medicaid Act, in order to improve access to high-quality, age-appropriate health care for all children in need. The **Children's Dental Health Project** is a national non-profit organization with the mission of creating and advancing innovative solutions to achieve oral health for all children so that they reach their full potential. The **National Center for Youth Law** (NCYL) is a private, non-profit organization devoted to using the law to improve the lives of poor children nation-wide. For almost 40 years, NCYL has worked to protect the rights of low-income children and to ensure that they have the resources, support and opportunities they need to become self-sufficient adults. Amicus **National Housing Law Project** is a charitable nonprofit corporation established in 1968 whose mission is to use the law to advance housing justice for low-income people by increasing, preserving and improving the supply of decent, affordable housing; by expanding and enforcing tenants' and homeowners' rights; and by increasing housing opportunities for people protected by fair housing laws. The **National REACH Coalition** was

established in 2004 to challenge community and faith-based organizations, public health agencies and academic institutions working with and in marginalized communities to find effective strategies and community-based interventions to eliminate inequities in health.

The **Disability Rights Legal Center** (DRLC) is a non-profit legal organization that was founded in 1975 to represent and serve people with disabilities. The DRLC assists people with disabilities in attaining the benefits, protections and equal opportunities guaranteed to them under the Rehabilitation Act of 1973, the Americans with Disabilities Act, Individual with Disabilities Education Improvement Act, and other federal and state laws. The **American Network of Community Options and Resources** (ANCOR) is a nationwide nonprofit association representing and advocating for more than 800 private providers of community living and employment services and supports to more than 500,000 people with disabilities of all ages. For more than 40 years, ANCOR has represented the capacity and ability of private providers to ensure access by the individuals they support, the majority of whom depend upon Supplemental Security Income and Medicaid.

Planned Parenthood Federation of America (PPFA) is the nation's largest and most trusted voluntary reproductive health care organization. PPFA's 83 affiliates operate more than 800 healthcare centers nationwide. In addition to providing reproductive health care, PPFA and its

affiliates are among the nation's most active and widely recognized advocates for increased access to comprehensive reproductive health services and education. PPFA is committed to promoting and preserving full reproductive choice for all people and to providing access to high quality, confidential, reproductive health services. The **National Family Planning & Reproductive Health Association** (NFPRHA) represents the broad spectrum of family planning administrators and clinicians who serve the nation's low-income and uninsured. NFPRHA's more than 400 institutional members operate or fund a network of more than 3,700 health centers and service sites in 48 states and the District of Columbia, providing family planning and other preventive health services to millions of low-income and uninsured individuals each year.

The mission of **National Latina Institute for Reproductive Health** (NLIRH) is to ensure the fundamental human right to reproductive health and justice for Latinas, their families and their communities through public education, community mobilization and policy advocacy. NLIRH is the nation's only reproductive health policy and advocacy organization working on behalf of the reproductive health and justice of the nation's Latina women. The **Black Women's Health Imperative** (Imperative) is the only Black national organization dedicated to promoting optimum health for Black women across the life span—physically, mentally and spiritually. The **National Asian Pacific American Women's Forum** (NAPAWF) is the only national, multi-issue Asian and Pacific Islander

(API) women's organization in the country. NAPAWF's mission is to build a movement to advance social justice and human rights for API women and girls. The **Asian & Pacific Islander American Health Forum** (APIAHF) is a health advocacy non-profit organization dedicated to health justice through improving the health and well-being of more than 17 million Asian Americans, Native Hawaiians, and Pacific Islanders living in the United States and its jurisdictions. APIAHF believes that all persons have the right to be healthy, to live in a thriving community, and to quality, affordable, and accessible health care.

SUMMARY OF ARGUMENT

The impact of California's across-the-board provider rate reductions on Medicaid beneficiaries' already insufficient access to health care is incompatible with and effectively nullifies the Equal Access Provision of the Social Security Act. If these rate reductions were to be implemented, even fewer providers in California would treat Medicaid patients, due largely to payment rates that are insufficient to cover the cost of providing the treatment. Delays in treatment and the inability to locate providers who will accept Medicaid payment are contributing to the poorer health of Medicaid beneficiaries' as compared to the general population.

The history and purpose of the Medicaid Act illustrate the need for and legality of private enforcement when states' violations of the Medicaid Act are harming program beneficiaries. The

Supreme Court has long recognized the right of program recipients and health care providers to enforce the Supremacy Clause and enjoin state laws that are inconsistent with the Medicaid Act or other provisions of the Social Security Act. The statutory scheme of the Medicaid Act does not preclude private enforcement. In other cases, the United States has repeatedly taken the position that private enforcement should complement federal agency remedies. Private enforcement is needed in these cases because the State's payment rates are too low to enlist sufficient numbers of Medicaid participating providers, thus creating barriers to care for Medicaid beneficiaries.

ARGUMENT

I. The History And Purpose Of Medicaid Show The Need For Private Enforcement.

Millions of Americans depend on their states' Medicaid programs operating as the Constitution and Congress intend. Over the history of the program, private enforcement has been the primary means of halting ongoing state violations of federal law and realizing Medicaid's promises and protections.

Title XIX of the Social Security Act established Medicaid in 1965. *See* 42 U.S.C. §§ 1396-1396w-5. Cooperatively funded by the federal and state governments, Medicaid is designed to provide low income program beneficiaries with

insurance that will allow them to obtain care and services from the private health care sector, including hospitals, doctors, pharmacies, and nursing homes. *See* Rand E. Rosenblatt et al., *Law and the American Health Care System* 415 (1997). Congress' "very clear ... intent [was] that the medical and remedial care and services made available to recipients under Title XIX be of high quality and in no way inferior to that enjoyed by the rest of the population." *Id.* at 416, *citing* U.S. Dep't of Health, Educ., and Welfare, *Handbook of Public Assistance Administration* § D-5140.

Before Medicaid was enacted, low income, uninsured people obtained health services through a patchwork of programs, such as hospital charity care and local programs for the poor. This system provided uneven coverage from state to state and within states. The Medicaid Act was intended to change this by providing for a uniform and statewide medical insurance program, while allowing for some variation among states. *See* Social Security Amendments of 1965, Pub. L. No. S9-97, 79 Stat. 266 (July 30, 1965).

Designed to address the more complex health needs of people with disabilities and the limited finances of low income people, Medicaid covers a range of necessary health and support services for people in need. Nearly 60 million people in the United States depend on Medicaid for their health care. Medicaid covers 30 million children (one in every three children in the United States) for medical, dental and developmental screening and

treatment. *See* Kaiser Comm'n on Medicaid & the Uninsured, *Medicaid Matters: Understanding Medicaid's Role in Our Health Care System* 1 (Mar. 2011) [hereinafter *Medicaid Matters*], http://www.kff.org/medicaid/upload/8165.pdf; Kaiser Comm'n on Medicaid & the Uninsured, *Top 5 Things to Know about Medicaid* 2 (2011) [hereinafter *Top 5 Things*], http://www.kff.org/medicaid/upload/8162.pdf. Nearly 15 percent of women between the ages of 15 and 44 rely upon Medicaid for services, including breast and cervical cancer screening and treatment, testing and treatment for sexually transmitted diseases, and pregnancy-related care. *See* Guttmacher Inst., *Women of Reproductive Age Hit Hard by Recession, New Census Data Show* (2010), http://www.guttmacher.org/media/inthenews/2010/09/17/index.html. Over 14 million older persons and people with disabilities depend on Medicaid. Twenty percent of all non-elderly people with disabilities in the United States depend on Medicaid to treat a range of conditions, including "physical impairments, blindness, limitations from spinal cord injury, severe mental and emotional conditions, and other disabling conditions, such as cerebral palsy, cystic fibrosis, Downs Syndrome, mental retardation, muscular dystrophy, autism, spina bifida, and HIV/AIDS." Andy Schneider et al., The Kaiser Comm'n on Medicaid and the Uninsured, *The Medicaid Resource Book* 18 (July 2002). Medicaid is the largest single purchaser of long-term care services for the elderly and non-elderly people with disabilities in the United States. For example, seven of every ten nursing home residents are covered by Medicaid, and Medicaid pays for 43

percent of the total long term care expenditures in the United States. *Medicaid Matters*, *supra*, at 2-3.

Over its forty-six year history, Medicaid has played a pivotal role in arranging for and funding health services. The program has resulted in numerous successes. It has reduced the numbers of uninsured, helped provide near-universal protection against communicable childhood diseases, played a major role in reducing infant mortality rates, and provided a critical life line to individuals with chronic and disabling conditions. *See* Schneider et al., *supra*, at 2; *Medicaid Matters*, *supra*, at 1-2. Medicaid is a cornerstone of the nation's health care system.

Medicaid is an entitlement program. Accordingly, "all individuals" who meet the eligibility requirements are entitled to receive a federally established set of benefits with "reasonable promptness." *See* 42 U.S.C. § 1396a(a)(10)(A), 42 U.S.C. § 1396a(a)(8). *See Schweiker v. Gray Panthers*, 453 U.S. 34, 36-37 (1981) ("An individual is entitled to Medicaid if he fulfills the criteria established by the State in which he lives."). The federal and participating state governments have a legal obligation to pay for and administer medical assistance needed by program beneficiaries in compliance with the requirements of the Medicaid Act and implementing regulations. *Id.* Thus, Medicaid coverage responds as emerging populations and economic needs arise, including rising unemployment, loss of private health care coverage, disasters, increasing disability rates, and an aging

society. *See Medicaid Matters, supra*, at 1-2; Schneider et al., *supra*, at 2.

Entitlement to Medicaid triggers legal rights, including the right to enforce certain statutory requirements that are placed on the states. It is this entitlement that makes Medicaid insurance and that assures individuals that coverage will be there when care is needed. Since the beginning of the Medicaid program, beneficiaries have been able to make their entitlement real by bringing *Ex parte Young* actions for prospective injunctive relief against state officials who are engaged in ongoing violations of federal law. Since the beginning of the Medicaid program, these cases have been based not only on 42 U.S.C. § 1983 but also on the Supremacy Clause. It is the Supremacy Clause that is at issue in this case.[2]

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[2] Section 1983 is not at issue here. *Gonzaga Univ. v. Doe*, 536 U.S. 273 (2002), clarified that private enforcement under § 1983 is limited to federal statutory provisions that reflect unambiguous congressional intent to benefit the individual plaintiffs. The enforcement test is well-established. Thirty-two Medicaid cases have been decided in the circuit courts of appeals since *Gonzaga*, with no splits among the circuits. *See* National Health Law Program, *Update on Private Enforcement of the Medicaid Act Pursuant to 42 U.S.C. § 1983* (June 2011), http://www.healthlaw.org. Unlike other appellate courts, *Pediatric Specialty Care v. Ark. Dep't of Human Servs.*, 443 F.3d 1015 (8th Cir. 2006), allowed enforcement of 42 U.S.C. § 1396a(a)(30)(A). However, that decision was vacated by *Selig v. Pediatric Specialty Care*, 551 U.S. 142 (2007).

II. California's Across-The-Board Medicaid Rate Cuts Are Incompatible With And Effectively Nullify The Equal Access Provision Of The Social Security Act.

When providers leave Medicaid programs due to inadequate payment rates, Medicaid patients experience problems locating alternative, appropriate care and are harmed. The U.S. Department of Health and Human Services recently proposed regulations that recognize that states' long running, budget-driven failures to comply with 42 U.S.C. § 1396a(a)(30)(A) are causing Medicaid recipients to be denied sufficient access to covered care and services. *See* 76 Fed. Reg. 26342, 26343 (May 6, 2011). And, several courts, looking at the issue both before and after *Gonzaga Univ. v. Doe*, 536 U.S. 273 (2002), have noted this national problem. *See, e.g.*, *Equal Access for El Paso, Inc. v. Hawkins*, 509 F.3d 697, 701 n.5 (5th Cir. 2007) (denying Medicaid recipients relief under § 1983 after discussing six such cases); *see also id.* (taking judicial notice of the Texas' Medicaid agency's statement that "[r]ate increases for physicians would promote access to care for Medicaid clients that would likely erode without the increase").[3]

Even before California enacted the cutbacks, its Medicaid provider payments were the forty-

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[3] *See, e.g.*, David L. Skaggs et al., *Access to Orthopedic Care for Children With Medicaid Versus Private Insurance: Results of a National Survey*, 26 J. Ped. Orthopaedics 400 (2006).

seventh *lowest* in the nation.[4] Access to office-based physicians in California is so limited that some recipients languish months before getting an appointment for treatment.[5] Patients of facilities with average wait times of 31 days or longer face significantly higher odds of dying than patients who were treated at medical facilities with shorter wait times.[6]

Participation in Medi-Cal among medical and surgical specialists is even lower than participation by primary care physicians because few doctors are willing to treat Medi-Cal patients because reimbursement rates are insufficient to cover the

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[4] Stephen Zuckerman, Amy Williams & Karen Stockley, Cal. HealthCare Found., *Medi-Cal Physician and Dentist Fees: A Comparison to Other Medicaid Programs and Medicare* 23 (Apr. 2009), http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/M/PDF%20MediCalFeeComparison.pdf.

[5] *See* Evan Halper, *Further Fee Cuts Force a Medi-Cal Exodus: Doctors are Rejecting New Patients*, L.A. Times, Mar. 24, 2008, 2008 WLNR 5628983; Duane W. Gang, *Riverside County Threatens to Pull Out of Medi-Cal Mental Health Program*, The Press Enterprise (Riverside, Cal.), Apr. 1, 2008, http://www.pe.com/localnews/healthcare/stories/PE_News_Local_H_board02.430192d.html.

[6] *E.g.* Julia C. Prentice & Steven D. Pizer, *Delayed Access to Health Care and Mortality*, 42 Health Services Res. 644-62 (2007); *cf.* Joanna Bisgaier & Karin V. Rhodes, *Auditing Access to Specialty Care for Children with Public Insurance*, 364 N. Eng. J. Med. 2324 (Jun. 16, 2011) (finding Medicaid recipients in Illinois wait 22 days longer than the privately insured for an appointment).

costs of treatment.[7] Pediatric surgeons, gynecologists and obstetricians, otolaryngologists, mental health professionals, and dentists have all reported that the actual cost of providing care is well above what Medi-Cal reimburses for their service.[8] Medi-Cal reimbursement rates have not significantly increased since 2001; in fact, California's rates increased only two percent from 2003 to 2008, over seven times less than the national average and ten times less than the rate of inflation over the same period.[9]

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[7] *See, e.g.*, Edward C. Wang et al., *Inequality of Access to Surgical Specialty Health Care: Why Children With Government-Funded Insurance Have Less Access Than Those with Private Insurance in Southern California*, 114 Pediatrics 584 (2004) (concluding 97 out of 100 surveyed otolaryngologists would offer an appointment to a privately insured child as compared to 27 for a child on Medi-Cal, with low monetary reimbursement given as chief reason for refusal).

[8] *See* David L. Skaggs et al., *Access to Orthopedic Care for Children with Medicaid Versus Private Insurance in California*, 107 Pediatrics 1405, 1406 (2001) (finding that cost of treatment by pediatric orthopedic surgeon exceeded Medi-Cal reimbursement); *Clayworth v. Bonta*, 295 F. Supp. 2d 1110, 1116 n.5 (E.D. Cal. 2003) (finding Medi-Cal reimbursement rates for OB/GYN services set below provider costs), *rev'd on other grounds* 140 Fed. App'x 677 (9th Cir. 2005); Halper, *supra* note 5 (reporting Medi-Cal reimbursement for tonsillectomies is insufficient to cover surgical costs); Wang, *supra* note 8 (finding Medi-Cal funds for mental health treatment do not cover costs); Martin Espinoza, *Dental Care Called a Health Care Crisis*, Press Democrat (Santa Rosa, Cal.), June 16, 2011, http://www.pressdemocrat.com/article/20110616/ARTICLES/110619585?p=all&tc=pgall (noting low dental participation because "it costs more to bill for Denti-Cal than what you get").

[9] Zuckerman, Williams & Stockley, *supra* note 4, at 11.

Since Medicaid recipients are in significantly poorer health than the general population, the consequences they face from reduced access to care leave them in a dire situation.[10] Lack of access to preventive care or treatment is the third leading cause of death for adults age 55-64, behind heart disease and cancer and the sixth-leading cause of death among adults ages 25 to 64, ahead of HIV/AIDS and diabetes.[11] Low Medi-Cal provider participation results in significantly worse and even grave health outcomes for recipients.

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[10] *See* Jack Hadley, Kaiser Comm'n on Medicaid and the Uninsured, *Sicker and Poorer: The Consequences of Being Uninsured* 46 (2002), http://www.kff.org/uninsured/upload/Full-Report.pdf.

[11] *See* Stan Dorn, Urban Inst., *Uninsured and Dying Because of It: Updating the Institute of Medicine Analysis on the Impact of Uninsurance on Mortality* 4 (2008), http://www.urban.org/UploadedPDF/411588_uninsured_dying.pdf; Karen Davis, Testimony before U.S. Senate, Special Comm. on Aging, The Commonwealth Fund, Time for Change: The Hidden Cost of a Fragmented Health Insurance System 2 (2003), http://www.commonwealthfund.org/publications/publications_show.htm?doc_id=221616.

III. The Supreme Court Has Consistently Recognized That Program Beneficiaries Can Enjoin State Laws That Are Invalid Under The Supremacy Clause, And Congress Has Recognized This Right.

On numerous occasions dating from the early 1970s, the Supreme Court has held that beneficiaries of Social Security Act programs can bring preemption actions to enjoin state laws that conflict with federal law and are, thus, "invalid under the Supremacy Clause." *Townsend v. Swank*, 404 U.S. 282, 285 (1971). In *Bennett v. Arkansas*, 485 U.S. 395, 397 (1988) (per curium), the Court held that a state statute that conflicted with the Social Security Act was preempted by operation of the Supremacy Clause. The Court noted that the Social Security Act "unambiguously rules out any attempt to attach Social Security benefits," while the Arkansas statute at issue in the case "just as unambiguously allows the State to attach those benefits." *Id.* at 397. The Court held that "this amounts to a 'conflict' under the Supremacy Clause—a conflict the State cannot win." *Id. See Blum v. Bacon*, 457 U.S. 132, 138 (1982) (holding state welfare regulations that conflicted with regulations promulgated pursuant to the Social Security Act "are invalid under the Supremacy Clause"); *N.Y. State Dep't of Social Servs. v. Dublino*, 413 U.S. 405, 423 n.29 (1973) (applying preemption analysis but finding no inconsistency, noting that "[c]onflicts [in Social Security Act programs], to merit judicial rather than cooperative federal-state resolution, should be of substance and not merely

trivial or insubstantial. But if there is a conflict of substance as to eligibility provisions, the federal law of course must control."); *Carleson v. Remillard*, 406 U.S. 598, 604 (1972) (holding that a California regulation excluding a parent's absence because of military service from the definition of "continued absence" from home conflicted with Social Security Act AFDC eligibility provisions and was invalid under the Supremacy Clause); *see also Ark. Dept. of Health & Human Servs. v. Ahlborn*, 547 U.S. 268 (2006) (assuming preemption cause of action without discussion). *See also PhRMA v. Walsh*, 538 U.S. 644 (2003) (plurality opinion) (deciding merits of preemption claim brought by provider organization); *Dalton v. Little Rock Family Planning Services*, 516 U.S. 474, 478 (1996) (applying Supremacy Clause in provider case and remanding for entry of injunction to extent state constitution conflicted with Medicaid Act). [12]

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[12] The petitioner and his *amici* voice concern that a litigation floodgate will be produced if plaintiffs are able to enjoin state laws that are invalid under the Supremacy Clause. However, in a line of cases dating back more than 30 years, each of the circuit courts of appeals already used Supremacy Clause analysis to determine the validity of state Medicaid laws without dire consequences coming to pass. *See, e.g., PhRMA v. Concannon*, 249 F.3d 66, 75 (1st Cir. 2001) (considering whether state statute conflicted with Medicaid so as to be invalid under Supremacy Clause); *Concourse Rehab. & Nursing Ctr., Inc. v. Whalen*, 249 F.3d 136, 146 (2d Cir. 2001); *Elizabeth Blackwell Health Ctr. for Women v. Knoll*, 61 F.3d 170, 178 (3d Cir. 1995 ("The Supremacy Clause requires invalidation of any state constitutional or statutory provision that conflicts with federal law ... and compels compliance by participants in Title XIX federal aid programs with federal law and regulations."); *Randall v. Lukhard*, 729 F.2d 966 (4th Cir. 1984) (en banc)

In 1994, Congress twice amended the Social Security Act to make clear that private causes of action are available. *See* 42 U.S.C. §§ 1320a-2, 1320a-10. Those amendments overruled parts of *Suter v. Artist M.*, 503 U.S. 347 (1992). They also affirmed the clear understanding of Congress that program beneficiaries would maintain access to the courts on the grounds that were recognized by this

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(adopting holding from *Randall v. Lukhard*, 709 F.2d 257, that a Virginia rule was invalid because it conflicted with a provision of the Medicaid Act); *Planned Parenthood of Hous. & Se. Tex. v. Sanchez*, 403 F.3d 324, 331 (5th Cir. 2005) ("[I]t is well-established that the federal courts have jurisdiction under 28 U.S.C. § 1331 over a preemption claim seeking injunctive and declaratory relief."); *Planned Parenthood Affiliates of Mich. v. Engler*, 73 F.3d 634, 637 (6th Cir. 1996) (because Michigan law "conflicts with the program requirements of Medicaid, it must be held invalid under the Supremacy Clause"); *Zbaraz v. Quern*, 596 F.2d 196, 202 (7th Cir. 1979) (remanding with instructions to enjoin enforcement of state law to extent it conflicted with Medicaid); *Lankford v. Sherman*, 451 F.3d 496, 509 (8th Cir. 2006) (granting recipients' request to enjoin Medicaid service cutback, holding "preemption claims are analyzed under a different test than section 1983 claims, affording plaintiffs an alternative theory for relief when state law conflicts with a federal statute or regulation."); *Lewis v. Hegstrom*, 767 F.2d 1371, 1375 (9th Cir. 1985) (applying "settled proposition that state regulations which are inconsistent with federal [Medicaid] law are invalid under the Supremacy Clause"); *Hern v. Beye*, 57 F.3d 906, 906 (10th Cir. 1995) (affirming injunction prohibiting enforcement of state law "to the extent it conflicts with federal Medicaid law"); *Planned Parenthood Fed'n v. Heckler*, 712 F.2d 650, 663-64 (D.C. Cir. 1983) ("It is elementary that under the Supremacy Clause of the Constitution states are not permitted to establish eligibility standards for federal assistance programs that conflict with the existing federal statutory or regulatory scheme.").

Court prior to 1992, the year *Suter* was decided. *See* H.R. Conf. Rep. No. 761, 103d Cong., 2d Sess., at 926 (1994), *reprinted in* 1994 U.S.C.C.A.N. 2901, 3257 ("The intent of this provision is to assure that individuals who have been injured by a State's failure to comply with the Federal mandate of the State plan titles of the Social Security Act are able to seek redress in the federal courts to the extent that they were able to prior to the decision in *Suter v. Artist M.*"). Sections 1320a-2 and 1320a-10 clearly mean that Congress intends preemption actions under the Supremacy Clause to live on as a means of preventing state officials from acting contrary to the requirements of the Social Security Act.

IV. The Medicaid Act's Statutory Scheme Is Not Inconsistent With The Need For Private Enforcement Of The Supremacy Clause To Prevent State Medicaid Officials From Acting Contrary To Federal Law.

In its brief supporting the petitioner, the United States argues that allowing Medicaid recipients and providers access to the courts is inconsistent with Medicaid's "statutory scheme" vesting enforcement authority in the Department of Health and Humans Services (DHHS). Brief for the United States as *Amicus Curiae* Supporting Petitioner at *10, *Douglas v. Indep. Living Ctr. of S. Cal. et al.* (May 2011) (Nos. 09-958, 09-1158, and 10-283) [hereinafter U.S. Indep. Living Ctr. Brief 2011]. This argument is inconsistent with Supreme Court precedent and the expressed opinion of Congress,

ignores DHHS's limited enforcement authority, and contradicts the position the United States has taken in other cases.

A statutory enforcement scheme either substitutes for private enforcement or it does not. In *Wilder*, this Court has held that the Medicaid Act does not contain a statutory scheme that would replace private enforcement. *See Wilder v. Va. Hosp. Ass'n*, 496 U.S. 498, 521-22 (1990); *see generally City of Rancho Palo Verdes v. Abrams*, 544 U.S. 113, 121-22 (2005) (listing Medicaid as a statute whose private judicial enforcement is not foreclosed based on a statutory enforcement scheme). When Congress amended the Social Security Act in 1994, it expressed its intent that private enforcement of the Social Security Act be determined according to the grounds applied in this Court's decisions prior to 1992. *See* 42 U.S.C. §§ 1320a-2, 1320a-10. Thus, the grounds established in *Wilder*, decided in 1990, are included in those grounds Congress approved in its 1994 amendments to the Social Security Act.

To be sure, Medicaid's statutory scheme does include a provision authorizing the Secretary of DHHS to enforce federal Medicaid law: 42 U.S.C. § 1396c authorizes the Secretary to terminate federal funding to states whose plans are not in compliance with the Act. Termination of federal funding is a draconian remedy, one that DHHS rarely uses. As noted by the United States when it opposed certiorari in these cases, "[P]rograms in which the drastic measure of withholding all or a major portion of federal funding if the only available remedy would

be generally less effective than a system that also permits awards of injunctive relief in private actions." Brief for the United States as *Amicus Curiae* at *19, *Maxwell-Jolly v. Indep. Living Ctr. of S. Cal.*, 572 F.3d 644 (9th Cir. 2009) on petition for cert December 2010 [hereinafter U.S. Indep. Living Ctr. Brief Dec. 2010].[13] *See also Va. Office for Prot. & Advocacy v. Stewart*, 131 S.Ct. 1632, 1639 n. 3 (2011) ("The fact that the Federal Government can exercise oversight of a federal spending program and even withhold or withdraw funds—which are the chief statutory features respondents point to—does not demonstrate that Congress has displayed an intent not to provide the more complete and more immediate relief that would otherwise be available under *Ex parte Young*." (citation omitted)).

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[13] The United States cites a regulation recently proposed by DHHS as evidence that DHHS is "committed to ensuring that" Medicaid beneficiaries have meaningful access to covered services. U.S. Indep. Living Ctr. Brief 2011 at *11-12 (citing Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. 26342 (May 6, 2011). Regardless of DHHS's alleged commitment, the proposed regulations do not contain an enforcement scheme that would render the need for private enforcement unnecessary. And while issuance of final regulations will hopefully provide guidance that states will follow, thereby decreasing their noncompliance with the statutory requirement of rates sufficient to assure equal access, these proposed regulations do not remove the necessity of private enforcement in situations where recalcitrant states continue to ignore the statutory mandate.

Despite the position taken here, the United States elsewhere recognizes that private enforcement complements the Secretary's oversight. For example, the United States is supporting private enforcement in a pending Medicaid case. In May 2011, Indiana enacted a statute that bars certain entities that perform abortions from participating in Medicaid. Medicaid-participating providers who were barred from providing services and Medicaid recipients who lost access to care filed suit in federal court arguing that the state law is preempted by a specific Medicaid Act provision and that they have a federal right to enforce that provision pursuant to 42 U.S.C. § 1983. The United States filed an amicus brief urging the court to enjoin implementation of the Indiana law. *See Statement of Interest of the United States at *21-22, Planned Parenthood of Indiana, Inc.* v. *Commissioner of the Ind. State Dept. of Health*, June 16, 2011 (S.D. Ind. No. 1:11-cv-00630-TWP-DKL) [hereinafter U.S. Planned Parenthood Brief]. According to the United States, the recipients' and providers' request for injunctive relief was "particularly necessary" because "Indiana has expressed its view that operating a 'non-compliant program' is a 'lawful option for the State under the [Medicaid] statute,' so long as the State is willing to 'risk that the Secretary will turn off the funding spigot." *Id.* at *21-22; *see also, e.g.*, Statement of Interest of the United States of America, *John B. v. Emkes*, Feb. 18, 2011 (M.D. Tenn. No. 3-98-0168) (asking court to deny Tennessee's request to terminate a consent decree because the Medicaid child health screening and treatment provisions are privately enforceable by

Medicaid recipients); Brief for the United States as Amicus Curiae Supporting Respondents at *30, *Blessing v. Freestone*, 520 U.S. 329 (1997) (No. 95-1441) (arguing that private enforcement is "an important complement to the Secretary's necessarily macroscopic oversight of the State, by assuring that States carry out the specific duties" of the Social Security Act and arguing that federal-state cooperative program of the Social Security Act does not contain statutory scheme that precludes private enforcement); U.S. Indep. Living Ctr. Brief Dec. 2010 at *19 (arguing against certiorari in these cases, pointing out that application of a contract analogy "overlooks the important role private parties can and often do play in vindicating federal law. A system that relies solely on agency review may be less effective than a system of agency review supplemented by private enforcement"). *Cf. Chisholm v. Hood*, 110 F. Supp. 2d 499 (E.D. La. 2000) (ordering State to cover physical and related therapy services for Medicaid eligible children six years after CMS had informed the State that the Act required coverage of these services).

Nor do the private parties have another adequate remedy, despite some suggestions to the contrary. *See PhRMA*, 538 U.S. at 675 (Scalia, J., concurring). In *PhRMA*, Justice Scalia suggested that the plaintiffs only remedy for a violation of the Medicaid Act is to ask the Secretary of DHHS to terminate federal funding and thereafter file an Administrative Procedural Act action if they are dissatisfied with the outcome. *Id.* at 675 (citing 5 U.S.C. § 706(2)(A)). There is no such statutory

scheme, *see* 42 U.S.C. § 1316 (citing § 1396c), nor is there such an administrative scheme for Medicaid recipients or providers. The federal Medicaid regulations allow a State to obtain administrative and judicial review when it is dissatisfied with the denial of a state plan amendment or federal withhold of funding. *See* 42 C.F.R. §§ 430.30-430.104. Only CMS and the State are automatic parties to the administrative hearing, *id.* at § 430.76, and only the State has a right to judicial review, *id.* at § 430.38. The regulations permit individuals to petition the federal agency for permission to participate in the hearing, but participation is within the discretion of the presiding officer at the hearing. *Id.* § 430.76. The ability of a recipient or provider to seek permission to participate in a State's hearing before the Department is not a statutory scheme that displaces private enforcement. *See Rosado v. Wyman*, 397 U.S. 397, 406 (1970) (refusing to attach significance to the fact that HEW (predecessor to DHHS) was engaged in a study of the issues before the court or to impose an "exhaustion of administrative remedies" requirement, noting that under the regulations recipients could not "have obtained an administrative ruling since HEW has no procedures whereby welfare recipients may trigger and participate in the Department's review of state welfare programs."); *Almenzares v. Wyman*, 453 F.2d 1075, 1087 (2d Cir. 1971) (finding administrative petition scheme inadequate because of the "inability of welfare recipients to trigger such a proceeding, along with the natural reluctance of HEW to embark on a course that could lead to withdrawal of federal aid"); *Ariz. Dep't of Pub. Welf. v. Dep't of Health,*

Educ. & Welf., 449 F.2d 456. 464, n.9 (9th Cir. 1971) (finding courts without jurisdiction to hear petitions from welfare recipients because § 1361 limits review to petitions from states and suggesting recipients bring direct declaratory action in district court finding such a remedy "preferable to a judgment ordering the cessation of the flow of federal [welfare] funds"). *See also Wilder*, 496 U.S. at 514 n.12 (acknowledging position of United States that there is no remedy under the APA because the decision to accept a states' assurance is entrusted to agency discretion); *id.* at 521-22 (rejecting argument that an action against the Secretary under the APA forecloses private enforcement).

CONCLUSION

For the foregoing reasons, *Amici Curiae* respectfully request this Court to affirm the judgment of the Circuit Court.

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RECORD
AND

Nos. 09-958, 09-1158, 10-283

IN THE

Supreme Court of the United States

TOBY DOUGLAS, DIRECTOR, CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES, *Petitioner*,

v.

INDEPENDENT LIVING CENTER OF SOUTHERN CALIFORNIA, INC., *et al.*, *Respondents.*

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TOBY DOUGLAS, DIRECTOR, CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES, *Petitioner*,

v.

CALIFORNIA PHARMACISTS ASSOCIATION, *et al.*, *Respondents.*

TOBY DOUGLAS, DIRECTOR, CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES, *Petitioner*,

v.

SANTA ROSA MEMORIAL HOSPITAL, *et al.*, *Respondents.*

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR AMERICAN CIVIL LIBERTIES UNION, NAACP LEGAL DEFENSE AND EDUCATIONAL FUND, INC., AND MEXICAN AMERICAN LEGAL DEFENSE AND EDUCATIONAL FUND AS AMICI CURIAE SUPPORTING RESPONDENTS

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INTEREST OF AMICI CURIAE[1]

The American Civil Liberties Union ("ACLU") is a nationwide, nonprofit, nonpartisan organization with over 500,000 members, dedicated to the principles of liberty and equality embodied in the Constitution and our nation's civil rights laws. Founded in 1920, the ACLU has vigorously defended civil liberties for over ninety years, working daily in courts, legislatures and communities to defend and preserve the individual rights and liberties that the Constitution and laws of the United States guarantee everyone in this country. The ACLU has appeared before this Court in numerous civil rights cases, both as direct counsel and as amicus curiae.

The NAACP Legal Defense & Educational Fund, Inc. ("LDF") is a non-profit legal organization established to assist African Americans and other people of color in securing their civil and constitutional rights. For more than six decades, LDF attorneys have represented parties and appeared as amicus curiae in litigation before the Supreme Court and other federal courts on matters of race discrimination, including through the type of direct constitutional enforcement actions at issue in this case.

The Mexican American Legal Defense and Education Fund ("MALDEF") is a national civil rights organization established in 1968. Its principal objective is

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[1] The parties have consented to the filing of this brief. Pursuant to Rule 37.3(a), written consents to the filing of this brief are on file with the Clerk of the Court. No counsel for a party authored this brief in whole or in part, and no person, other than the amici curiae, their members, or their counsel made any monetary contribution to the preparation or submission of this brief.

to promote the civil rights of Latinos living in the United States through litigation, advocacy and education. MALDEF has represented Latino and minority interests in civil rights cases in the federal courts throughout the nation, including the Supreme Court. MALDEF's mission includes a commitment to protect the rights of immigrant Latinos in the United States, and MALDEF has asserted preemption theories in federal court to further this commitment.

SUMMARY OF ARGUMENT

I. Enforcement of the Constitution is not dependent on affirmative action by the political branches of government. Rather, from this Nation's earliest times to the present, the federal courts have consistently exercised their equitable powers to compel compliance with the Constitution, without suggesting the necessity for a statutory vehicle, such as 42 U.S.C. § 1983, for such authority. Those equitable powers have been, and continue to be, particularly important for minorities, immigrants, low-income individuals, and others whom our majoritarian political processes are often unwilling or unable to protect against constitutional violations. Indeed, direct actions brought to enforce compliance with the Constitution have resulted in many of this Court's most important civil-rights and civil-liberties decisions, including *Bolling* v. *Sharpe*, 347 U.S. 497 (1954), *Terry* v. *Adams*, 345 U.S. 461 (1953), *Truax* v. *Raich*, 239 U.S. 33 (1915), and *Pierce* v. *Society of Sisters*, 268 U.S. 510 (1925); in none of those cases did the Court suggest that it was acting under § 1983 or another statutory vehicle. That history is consistent with the many cases in which this Court enforced other provisions of the Constitution, such as the Contracts Clause and Commerce Clause, as well as structural principles of federalism and separation of powers.

Such direct actions are also available to enforce a claim of preemption under the Supremacy Clause, *see* U.S. Cert. Amicus Br. 15-18, including where the preemption is based on a statute enacted under Congress's spending power. This Court has entertained and sustained many preemption claims in that context, recognizing the appropriateness of direct actions to vindicate the supremacy of federal law. Petitioner suggests that such direct actions should not be allowed, or drastically restricted to narrow contexts, but that rule would seriously undermine federal law. In many contexts, a direct action is the only way in which the supremacy of federal law could be established. Requiring litigants asserting a Supremacy Clause claim to wait for a state-court action would be grossly inefficient and could result in federal law being undermined by invalid state laws.

II. Direct actions remain critical to vindicate the supremacy of federal law. This is especially true for racial minorities, immigrants, and low-income individuals, who in many circumstances have difficulty obtaining access to, or support from, the federal political branches, and who often depend on a judicial remedy to prevent enforcement of state laws that conflict with federal laws. In contexts as diverse as immigration, housing, and public assistance, direct actions remain the only effective avenue to ensure the supremacy of federal law. Eliminating that avenue would seriously undermine federal law, because other avenues of enforcement of federal law—such as termination of federal funding or enforcement actions brought by the United States—are highly impractical and offer little or no hope for successful enforcement on behalf of individuals directly harmed by states' illegal conduct. Absent direct actions brought to establish the supremacy

of federal law by those most directly affected by pre-empted state laws, there could well be no meaningful remedy for state noncompliance with the Constitution's fundamental safeguards.

ARGUMENT

I. THE COURTS' LONGSTANDING AUTHORITY TO ENFORCE THE CONSTITUTION THROUGH DIRECT ACTIONS HAS BEEN PARTICULARLY CRITICAL FOR CIVIL RIGHTS AND CIVIL LIBERTIES

This Court has long recognized that the strictures of the Constitution may be enforced through direct actions for equitable relief, regardless whether Congress has enacted legislation specifically establishing a cause of action for such relief. So long as the court has subject-matter jurisdiction over the claim, separate legislation establishing a cause of action has never been necessary for a plaintiff to obtain forward-looking relief from unconstitutional conduct. Rather, the traditional equitable authority of the courts has always been deemed sufficient to provide such a remedy. The Court has adhered to this principle in many contexts—whether the constitutional claim was brought against federal, state, or local officials; whether the claim was brought to enforce individual constitutional rights or to enforce structural principles in the Constitution; and whether or not the claim was brought to preclude an anticipated enforcement action.

The courts' inherent equitable authority to compel compliance with the Constitution is implicit in the structure of the Constitution itself, and in the Constitution's status as the supreme law of the land. *See* Santa Rosa Br. 13-18. As the Court recognized in *Marbury* v. *Madison*, 5 U.S. (1 Cranch) 137 (1803), judicial review is necessary as a check against the aggrandizement of

power by the political branches. These structural principles not only protect each branch from intrusion by the others, but they also protect individuals from the abuse of governmental power. *See Bond* v. *United States*, 131 S. Ct. 2355, 2363-2364 (2011). Thus, as Chief Justice Marshall explained, "[t]he very essence of civil liberty" is "the right of every individual to claim the protection of the laws, whenever he receives an injury." 5 U.S. (1 Cranch) at 163. Although legislation may channel the way in which constitutional claims are entertained by the courts, the courts have long understood that the right to compel compliance with the Constitution is not contingent on the assent of the political branches. *See Webster* v. *Doe*, 486 U.S. 592, 603 (1988) (stressing that a "'serious constitutional question'" would arise if the political branches attempted to preclude any judicial forum for constitutional claims by failing to make statutory allowance for such claims); *see also* Federalist No. 78 (Hamilton) ("[T]he courts were designed to be an intermediate body between the people and the legislature, in order ... to keep the latter within the limits assigned to their authority.").

A. Civil Rights Claims Have Long Been Enforceable Through Direct Actions

The ability to enforce rights directly under the Constitution has been particularly important for minorities, immigrants, low-income individuals, and other persons who have faced systemic barriers in our majoritarian political process and thus have often depended on the federal courts to secure their rights when Congress and the Executive Branch have been

unable or unwilling to do so.[2] Some of this Court's (and this country's) most significant steps toward achieving equality and liberty have resulted from plaintiffs' enforcement of their rights directly under the Constitution. And that was particularly true in the long period before this Court's decision in *Monroe* v. *Pape*, 365 U.S. 167 (1961), revived 42 U.S.C. § 1983 as a vehicle for enforcement of constitutional rights.

Many landmark civil rights decisions resulted from direct actions to enforce the Constitution. One such case, *Bolling* v. *Sharpe*, 347 U.S. 497 (1954), is a keystone of this Court's desegregation precedent. The *Bolling* plaintiffs challenged racial segregation in the public schools of the District of Columbia under the Due Process Clause of the Fifth Amendment. The Court ruled unanimously for the plaintiffs, holding that racial segregation in the District's public schools violated the Fifth Amendment. The Court nowhere suggested that the plaintiffs' ability to be heard on their due process claim depended on their being able to point to a statutory cause of action, such as § 1983.[3]

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[2] *See Chambers* v. *Florida*, 309 U.S. 227, 241 (1940) ("Under our constitutional system, courts stand against any winds that blow as havens of refuge for those who might otherwise suffer because they are helpless, weak, outnumbered, or because they are non-conforming victims of prejudice and public excitement.").

[3] Indeed, at the time, it was an open question whether § 1983 applied to the District of Columbia. The Court did not address the question until *District of Columbia* v. *Carter*, 409 U.S. 418 (1973), which held that § 1983 did not apply to persons acting under color of D.C. law. Congress later amended § 1983 to apply to such persons. Act of Dec. 29, 1979, Pub. L. No. 96-170, § 1, 93 Stat. 1284.

Desegregation in higher education was advanced through another direct constitutional action, *McLaurin* v. *Oklahoma State Regents for Higher Educ.*, 339 U.S. 637 (1950). After the University of Oklahoma denied the plaintiff admission to graduate school on the basis of his race, McLaurin sued for injunctive relief, alleging that the state law prohibiting integrated schools deprived him of equal protection. The district court agreed. The Oklahoma legislature then amended the statute, allowing the university to admit the plaintiff but restricting him to segregated facilities. The plaintiff returned to the district court to seek injunctive relief, which the district court denied. The Supreme Court reversed, holding that the amended state law permitting segregated facilities deprived McLaurin of his right to equal protection. *Id.* at 642. The Court nowhere suggested that McLaurin's ability to bring his constitutional claim depended on a statutory cause of action.[4]

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[4] Another landmark desegregation case, *Brown* v. *Board of Education*, 347 U.S. 483 (1954)—which also did not mention the predecessor statute to § 1983—can be seen as a direct constitutional action as well, although commentators disagree on how to characterize that case. *Compare* Berzon, *Securing Fragile Foundations: Affirmative Constitutional Adjudication in Federal Courts*, 84 N.Y.U. L. Rev. 681, 685-686 (2009) (characterizing *Brown* as a direct constitutional action) *and* Bandes, *Reinventing* Bivens: *The Self-Executing Constitution*, 68 S. Cal. L. Rev. 289, 355 (1995) (same), *with* Blackmun, *Section 1983 and Federal Protection of Individual Rights—Will the Statute Remain Alive or Fade Away?*, 60 N.Y.U. L. Rev. 1, 1-2, 19 (1985) (characterizing *Brown* as a § 1983 suit) *and* Smolla, *Federal Civil Rights Acts* § 14:2, at 391-392 (3d ed. 2011) (same). Regardless, *Bolling* demonstrates that there is a direct right of action under the Constitution to challenge the legality of racial segregation in public schools.

In an equally important decision for minority voting rights, the Court in *Terry* v. *Adams*, 345 U.S. 461 (1953), sustained a constitutional challenge by black citizens to one of a series of schemes to maintain whites-only primary elections in Texas. Having abandoned their claim for damages, the *Terry* plaintiffs rested their equitable claims directly on the Fourteenth and Fifteenth Amendments. *Id.* at 478 nn.2 & 3 (Clark, J. concurring). The Court struck down the discriminatory primary as unconstitutional. *Id.* at 470; *see also id.* at 467 n.2 (plurality opinion) (noting that the Fifteenth Amendment is "'self-executing'"). In so ruling, the Court relied on its earlier decision in *Guinn* v. *United States*, 238 U.S. 347 (1915), which invalidated grandfather clauses under the Fifteenth Amendment, even though Congress had not enacted specific legislation reaching primary elections, based on "the self-executing power of the 15th Amendment," *id.* at 368.

Several of this Court's pathmarking decisions establishing the rights of noncitizens also reached the Court by way of direct action. For example, in *Truax* v. *Raich*, 239 U.S. 33 (1915), this Court held that an Arizona statute prohibiting the employment of noncitizens violated their rights to equal protection under the Fourteenth Amendment. The Court did not suggest the case was before it under a statutory cause of action such as § 1983, but rather stressed that the plaintiff had invoked the equitable power of the district court to restrain unconstitutional action. Similarly, in *Terrace* v. *Thompson*, 263 U.S. 197 (1923), the Court, although rejecting an immigrant's constitutional claim on the merits, stressed that the power to compel compliance with the Constitution rested on the courts' traditional equitable powers, noting that equity jurisdiction will be exercised to enjoin unconstitutional state laws "wherever

it is essential in order effectually to protect property rights and the rights of persons against injuries otherwise irremediable." *Id.* at 214.

Similarly, one of this Court's leading decisions on the meaning of "liberty" within the Due Process Clause, *Pierce* v. *Society of Sisters*, 268 U.S. 510 (1925), arrived at the Court by way of a direct action brought to enforce the Fourteenth Amendment and to prevent Oregon officials from implementing a state compulsory education law that would have forced all children to attend public schools. *See id.* at 530. The Court nowhere referred to a statutory cause of action under which the claim for equitable relief was brought. The district court where the case was originally brought observed that "[t]he question as to equitable jurisdiction is a simple one, and it may be affirmed that, without controversy, the jurisdiction of equity to give relief against the violation or infringement of a constitutional right, privilege, or immunity, threatened or active, to the detriment or injury of a complainant, *is inherent*, unless such party has a plain, speedy, and adequate remedy at law." *Society of Sisters* v. *Pierce*, 296 F. 928, 931 (D. Or. 1924) (emphasis added).

This theme—that the courts have inherent authority to restrain violations of the Constitution, so long as they have subject-matter jurisdiction—runs throughout the Court's decisions and has never been seriously questioned. In *Bell* v. *Hood*, 327 U.S. 678, 684 (1946) (footnote omitted), the Court observed that "it is established practice for this Court to sustain the jurisdiction of federal courts to issue injunctions to protect rights safeguarded by the Constitution and to restrain individual state officers from doing what the 14th Amendment forbids the State to do"—without any mention of a statutory vehicle such as § 1983. And although Jus-

tices of this Court have debated whether *damages* should be available to remedy *past* constitutional violations in the absence of a statutory cause of action, *see Bivens* v. *Six Unknown Named Agents of Federal Bureau of Narcotics*, 403 U.S. 388 (1971); *Correctional Services Corp.* v. *Malesko*, 534 U.S. 61, 75 (2001) (Scalia, J., concurring), the Court has never questioned courts' inherent authority to enjoin threatened or ongoing constitutional violations. *See, e.g., Carlson* v. *Green*, 446 U.S. 14, 42 (1980) (Rehnquist, J., dissenting) (criticizing direct constitutional actions for damages, but acknowledging tradition of direct constitutional actions for equitable relief, and noting that "[t]he broad power of federal courts to grant equitable relief for constitutional violations has long been established").

Moreover, contrary to petitioner's assertion (Pet. Br. 43-44), the Court has entertained such direct actions to enforce the Constitution regardless whether that claim was brought to prevent a threatened enforcement action and might have been raised in defense to such an action. *See infra* pp. 18-22; U.S. Cert. Amicus Br. 17-18 (acknowledging that "not all of this Court's" preemption cases involved claims raised in defense to enforcement actions). Indeed, where the plaintiff could not bring the claim defensively to an enforcement action, the case for exercise of the courts' equity power is particularly compelling because the plaintiff could well have no other way to vindicate his constitutional rights. In the desegregation and voting rights cases discussed above, for example, there was no clear way that the plaintiffs seeking to vindicate their constitutional rights could have obtained a ruling on the merits of their claims except through affirmative litigation. And in *Truax*, the district court observed that the noncitizen's constitutional claim presented an appropriate

case for the exercise of equity power because under the challenged Arizona statute only employers, not (noncitizen) employees, were subject to criminal prosecution; thus the noncitizen employee would have had no other forum for his claim to be heard. *See Raich* v. *Truax*, 219 F. 273, 283-284 (D. Ariz. 1915). If a plaintiff seeking to enforce the Constitution has no other forum in which to raise his claim, that provides a stronger—not a weaker—rationale for the courts to entertain a direct equitable action.

B. Constitutional Claims Outside The Civil Rights Context Have Also Long Been Enforceable Through Direct Actions

These civil rights cases are in keeping with historical tradition, in which this Court has long recognized direct actions to enforce constitutional provisions, regardless whether Congress has provided a specific statutory vehicle for enforcement of the Constitution.

One of the earliest examples is *Osborn* v. *Bank of United States*, 22 U.S. (9 Wheat.) 738 (1824). This Court resolved the Bank of the United States' suit against the Ohio Auditor for collecting a state tax that conflicted with the federal statute that created the Bank. Although no statute created a cause of action for the Bank, this Court found that the dispute warranted the "interference of a Court," and it held the Ohio law unconstitutional on the ground that it was "repugnant to a law of the United States" and therefore void under the Supremacy Clause. *Id.* at 838, 868.

In the years after *Osborn*, and with increasing frequency after Congress provided for federal-question jurisdiction in 1875, courts routinely entertained suits to enforce directly a broad range of constitutional provisions, including the Contracts Clause, the Fourteenth

Amendment's Due Process Clause, and the dormant Commerce Clause. *See, e.g., Hays* v. *Port of Seattle*, 251 U.S. 233 (1920) (Due Process Clause and Contracts Clause); *Vicksburg Waterworks Co.* v. *Mayor & Aldermen of Vicksburg*, 185 U.S. 65 (1902) (Contracts Clause); *Chicago Burlington & Quincy R.R. Co.* v. *City of Chi.*, 166 U.S. 226 (1897) (Due Process Clause); *Scott* v. *Donald*, 165 U.S. 107 (1897) (Commerce Clause); *Allen* v. *Baltimore & Ohio R.R. Co.*, 114 U.S. 311 (1884) (Contracts Clause). Particularly noteworthy are the direct actions for equitable relief brought to enforce the Contracts Clause, because it still is not settled in this Court whether claims under the Contracts Clause may be brought under § 1983. *See Dennis* v. *Higgins*, 498 U.S. 439, 456-457 (1991) (Kennedy, J., dissenting); *Crosby* v. *City of Gastonia*, 635 F.3d 634, 640-641 (4th Cir. 2011) (noting issue), *petition for cert. filed*, No. 10-1479 (U.S. June 8, 2011). Nonetheless, the Court explained in *Vicksburg Waterworks* that the Contracts Clause claim was properly before it because "the case presented by the bill is within the meaning of the Constitution of the United States and within the jurisdiction of the circuit court as presenting a Federal question"—without suggesting that a statutory cause of action was also necessary. 185 U.S. at 82. The Court more recently upheld a Contracts Clause claim in such a direct-action posture in *Allied Structural Steel Co.* v. *Spannaus*, 438 U.S. 234 (1978), without discussing whether the claim might have been brought under § 1983.

One of the most notable of these cases was *Ex Parte Young*, 209 U.S. 123 (1908). After the Minnesota Attorney General signaled his intention to enforce a state law limiting the rates that railroads could charge, a group of railroad shareholders sued him to enjoin en-

forcement of that law, arguing that it violated the Commerce Clause and Due Process Clause of the Fourteenth Amendment. The Court concluded that the Eleventh Amendment does not bar suits against state officers to enjoin violations of the Constitution or federal law. *Id.* at 159-160. The Court also concluded that the federal courts had jurisdiction because the case raised "Federal questions" directly under the Constitution. *Id.* at 143-145. The Court thus viewed the Constitution—paired with the federal-question jurisdiction statute—as providing the basis of the plaintiffs' right to sue a state officer to enjoin an alleged constitutional violation. As this Court has observed, "the availability of prospective relief of the sort awarded in *Ex parte Young* gives life to the Supremacy Clause. Remedies designed to end a continuing violation of federal law are necessary to vindicate the federal interest in assuring the supremacy of that law." *Green* v. *Mansour*, 474 U.S. 64, 68 (1985). Indeed, scholars have concluded that "the best explanation of *Ex parte Young* and its progeny is that the Supremacy Clause creates an implied right of action for injunctive relief against state officers who are threatening to violate the federal Constitution and laws."[5]

Also demonstrating this principle are the numerous cases in which this Court has resolved structural constitutional claims brought against the federal government without suggesting that a statutory cause of action was necessary for those claims to be before the courts, and where there was no evident alternative forum for those claims to be heard (such as under the

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[5] Wright et al., *Federal Practice and Procedure* § 3566, at 292 (3d ed. 2008).

Administrative Procedure Act or in defense to an enforcement action). *See Printz* v. *United States*, 521 U.S. 898 (1997); *New York* v. *United States*, 505 U.S. 144 (1992); *South Carolina* v. *Baker*, 485 U.S. 505 (1988); *South Dakota* v. *Dole*, 483 U.S. 203 (1987); *Youngstown Sheet & Tube Co.* v. *Sawyer*, 343 U.S. 579 (1952); *see also Free Enterprise Fund* v. *Public Co. Accounting Oversight Bd.*, 130 S. Ct. 3138, 3151 & n.2 (2010) (ruling that Appointments Clause claim was properly before the courts, despite the absence of a statutory cause of action).[6]

C. The Supremacy Clause As Well May Be Enforced Through Direct Equitable Actions

Given the courts' historical willingness to entertain direct actions to enforce the Constitution, it would be surprising to learn that the Supremacy Clause, alone among the Constitution's provisions, could not be so enforced. As the Framers explained, the Supremacy Clause is fundamental to the Constitution, for if the laws of the United States "were not to be supreme," then "they would amount to nothing." Federalist No. 33 (Hamilton). The Supremacy Clause thus "flows immediately and necessarily from the institution of a federal government." *Id.*; *see also* Santa Rosa Br. 30-31. In keeping with historical tradition, direct actions under the Supremacy Clause have played an important

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[6] In its most recent Term, this Court reiterated that it will entertain individuals' challenges based on federal structural constitutional principles. *See Bond*, 131 S. Ct. at 2363-2364 ("The individual, in a proper case, can assert injury from governmental action taken in excess of the authority that federalism defines."); *see also id.* at 2365 ("The structural principles secured by the separation of powers protect the individual as well.").

role in vindicating the supremacy of federal law, as *Osborn* and *Ex parte Young* illustrate.

This Court has implicitly recognized a right of action under the Supremacy Clause to enjoin preempted state law in many contexts—including cases where the preempting federal law was enacted pursuant to Congress's Spending Clause powers, and where state participation in the federal program was voluntary.[7] By routinely resolving such claims on the merits, without regard to whether a federal statute confers a right of action, this Court has established not only that federal courts have subject-matter jurisdiction over claims to enjoin preempted state law but that there is a right of action under the Supremacy Clause for such claims. *See* U.S. Cert. Amicus Br. 15-18 (recognizing that the Court has often decided preemption claims on their merits, implicitly assuming that a cause of action exists under the Supremacy Clause to challenge preempted state law). It is particularly noteworthy that the Court entertained such Supremacy Clause claims without ref-

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[7] *See, e.g., Arkansas Dep't of Health & Human Servs.* v. *Ahlborn*, 547 U.S. 268 (2006) (federal Medicaid law preempts state statute imposing liens on tort settlement proceeds). In *Pharmaceutical Research & Manufacturers of America* v. *Walsh*, 538 U.S. 644 (2003) *("PhRMA")*, seven Justices (four in the plurality and three in dissent) reached and resolved the merits of plaintiff's claim that the challenged state law was preempted by the federal Medicaid statute. *See id.* at 649-670 (plurality opinion) (finding on the merits that state law was not preempted); *id.* at 684 (O'Connor, J., concurring in part and dissenting in part) (finding on the merits that the state law was preempted). By so doing, seven Justices implicitly concluded both that the Court had the authority to resolve the case under federal-question jurisdiction and that the plaintiff had a claim to injunctive relief under the Supremacy Clause. *See id.* at 668 (plurality opinion).

erence to a statutory cause of action long before *Maine* v. *Thiboutot*, 448 U.S. 1 (1980), established that § 1983 may be used to vindicate federal statutory—in addition to federal constitutional—rights against state interference. *See, e.g.*, *Florida Lime & Avocado Growers, Inc.* v. *Paul*, 373 U.S. 132 (1963); *Hines* v. *Davidowitz*, 312 U.S. 52 (1941); *Asakura* v. *City of Seattle*, 265 U.S. 332 (1924). That tradition continues unbroken to this day.[8]

In short, "the rule that there is an implied right of action to enjoin state or local regulation that is preempted by a federal statutory or constitutional provi-

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[8] *See, e.g.*, *Cuomo* v. *Clearing House Ass'n, L.L.C.*, 129 S. Ct. 2710 (2009) (regulations promulgated under National Bank Act preempt enforcement of executive subpoenas from state Attorney General); *Rowe* v. *New Hampshire Motor Transp. Ass'n*, 552 U.S. 364 (2008) (Federal Aviation Administration Authorization Act preempts state requirements related to the transport of tobacco products); *Ahlborn*, 547 U.S. 268 (federal Medicaid law preempts state statute imposing liens on tort settlement proceeds); *Watters* v. *Wachovia Bank, N.A.*, 550 U.S. 1 (2007) (National Bank Act preempts state supervision of mortgage-lending activities by national bank affiliates); *PhRMA*, 538 U.S. at 649-670 (plurality opinion) (Medicaid Act did not preempt state prescription-drug rebate law); *Lorillard Tobacco Co.* v. *Reilly*, 533 U.S. 525 (2001) (Federal Cigarette Labeling and Advertising Act preempts state regulations on cigarette advertising); *Crosby* v. *National Foreign Trade Council*, 530 U.S. 363 (2000) (federal Burma statute preempts state statute barring state procurement from companies that do business with Burma); *United States* v. *Locke*, 529 U.S. 89 (2000) (various federal statutes preempt state regulations concerning, *inter alia*, the design and operation of oil tankers); *Foster* v. *Love*, 522 U.S. 67 (1997) (federal election statute preempts Louisiana's "open primary" statute); *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85 (1983) (ERISA preempts portions of state benefits law); *see also* Sloss, *Constitutional Remedies for Statutory Actions*, 89 Iowa L. Rev. 355, 365-400 (2004) (canvassing this Court's case law on preemption claims).

sion—and that such an action falls within federal question jurisdiction—is well established." *Hart & Wechsler's The Federal Courts & The Federal System* 807 (Fallon et al. eds., 6th ed. 2009) (collecting cases).

This Court's decision in *Golden State Transit Corp. v. City of Los Angeles*, 493 U.S. 103 (1989), is consistent with this analysis. That decision makes clear that § 1983 does not provide a home for all preemption claims (but may be used only to vindicate federal "rights"), *see id.* at 107, but it nowhere suggests that preemption claims may not be directly asserted merely because § 1983 does not provide a vehicle to do so. That the Supremacy Clause itself "does not create rights *enforceable under § 1983*," *id.* (emphasis added) means only that certain preemption claims may not be brought under § 1983, not that such claims may not be brought at all. Indeed, the dissent in *Golden State Transit*, which would have denied the award of money damages under § 1983, made that very point, explaining that denying relief under § 1983 "would not leave the company without a remedy" because "§ 1983 does not provide the exclusive relief that the federal courts have to offer," and that the plaintiffs could seek an injunction on preemption grounds. *Id.* at 119 (Kennedy, J., dissenting).[9]

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[9] Section 1983 is not duplicative of the right of action for injunctive relief under the Supremacy Clause. By enacting § 1983, Congress expanded the kinds of state action that private litigants could challenge and the remedies they could seek beyond those available in suits directly under the Constitution. *See* Cal. Pharmacists Br. 35-39; Dominguez Br. 29-34; Santa Rosa Br. 27-28. That § 1983 has been an important mechanism to secure constitutional rights by providing damages remedies against state and local officials does not mean that § 1983 is the only avenue through which unconstitutional state action can be challenged.

Although petitioner and his amici have acknowledged that the federal courts have previously entertained direct actions to enforce the Constitution (including the Supremacy Clause), they have suggested that, where Congress has not provided a vehicle such as § 1983 for such claims to be entertained, then those claims should be remitted to state courts, under whatever procedures the States might have provided for them to be heard—or that, at most, the federal courts should entertain such direct actions only when they are brought to prevent the threatened imminent enforcement of an unconstitutional or preempted state law. *See* Pet. Br. 43-44; National Governors Ass'n et al. Amicus Br. 22-26; U.S. Merits Amicus Br. 19-22.[10] Those suggestions should be rejected for several reasons.

First, those arguments are inconsistent with this Court's uniform precedent. This Court has entertained and sustained many direct equitable actions under the Constitution, including the Supremacy Clause, and also including preemption claims based on a federal spending statute, even when there was no evident enforcement action to which the federal claim might be raised as a defense. For example, in *Crosby* v. *National Foreign Trade Council*, 530 U.S. 363 (2000), the challenged

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[10] The United States has taken the position elsewhere that the Supremacy Clause provides a direct cause of action that is not limited to asserting a defense to a state enforcement action. *See* Compl., *United States* v. *Arizona*, 10-cv-01413 (D. Ariz. July 6, 2010) (filed by the United States as plaintiff challenging Arizona immigration law, seeking declaratory and injunctive relief and asserting "Violation of the Supremacy Clause" as its first cause of action); Compl., *United States* v. *Alabama*, 11-cv-02746 (N.D. Ala. Aug. 1, 2011) (similar, in challenge to Alabama law).

Massachusetts law barred government procurement of goods and services from companies doing business with Burma. *See id.* at 366-367. There was no "enforcement" action in which the companies could raise preemption as a defense; the plaintiffs simply could no longer get government contracts. This Court held that the state law was preempted, necessarily presuming that there was a right of action under the Supremacy Clause that could be asserted directly and not merely in defense of an enforcement action. *Id.* at 367; *see also PhRMA*, 538 U.S. at 649-670 (plurality opinion); *id.* at 684 (O'Connor, J., concurring in part and dissenting in part) (seven Justices resolving Medicaid-based preemption claim on the merits where that claim was raised affirmatively and not in defense to an enforcement action); *supra* pp. 10-11 (noting other examples of direct constitutional claims being entertained where they could not have been raised as defenses to enforcement actions).

Second, a rule requiring preemption claims to be advanced defensively only, while allowing claims based on a violation of constitutional *rights* to go forward in federal court under § 1983, would be extraordinarily inefficient and would undermine the effective vindication of federal law. Litigants frequently pursue both preemption theories and other constitutional claims. This Court's cases teem with examples: businesses commonly pursue both preemption claims and claims under the Commerce, Contracts, or Due Process Clauses; immigrants pursue both preemption claims and claims under the Equal Protection Clause and First Amendment; racial minorities pursue both statutory claims and claims under the Fourteenth and Fifteenth Amendments. Very often, courts turn to the preemption claim first in order to avoid reaching difficult con-

stitutional questions. *See, e.g., Crosby*, 530 U.S. 363 (holding state procurement statute preempted by federal Burma statute, and thereby avoiding dormant Foreign Commerce Clause claim); *Hines*, 312 U.S. 52 (holding Pennsylvania registration law for noncitizens preempted by federal legislation enacted while the case was before the Supreme Court, and thus avoiding equal protection claim).

If litigants could not pursue both preemption claims (directly) and other constitutional claims (under § 1983) in a single action for equitable relief, but were required to pursue preemption theories not cognizable under § 1983 only in state court, then they would be forced either to divide their federal claims between federal and state courts—which could well be barred by rules against splitting causes of action—or to forgo the federal forum for their § 1983 claims—which would be contrary to the strong congressional policy in favor of affording a federal forum for such claims. *See, e.g., Patsy* v. *Board of Regents of Fla.*, 457 U.S. 496 (1982). The far more efficient and sensible rule, as well as the one more consistent with this Court's decisions, is to allow equitable claims based on all provisions of the Constitution, including the Supremacy Clause, to be entertained in affirmative litigation through an action directly under the Constitution.

In addition, the rule proposed by petitioner and its amici would not adequately assure the supremacy of federal law. Many Supremacy Clause claims cannot be raised defensively at all, because there is no enforcement action in which they can be raised; in such circumstances, an affirmative direct action under the Constitution is the only way in which the supremacy of federal law could be established. *See* Sloss, *Constitutional Remedies for Statutory Actions*, 89 Iowa L. Rev. 355,

406 (2004) (discussing such claims). And even when a litigant might be able to assert his federal claim in defense of state enforcement actions or in defense to state common law claims, his ability to establish the supremacy of federal law should not be dependent on the venues that state law has happened to make available.[11] Indeed, this Court has long recognized that "it is one of the most valuable features of equity jurisdiction, to anticipate and prevent a threatened injury." *Vicksburg Waterworks*, 185 U.S. at 82.

The history of the civil rights movement in this country well illustrates the need to enforce federal rights in the federal courts, without reliance on legislative grace or the vagaries of state law. Had § 1983 never been enacted, it could hardly be the case that state laws providing for segregated schools, white primaries, and restrictions on immigrants could have gone unchallenged. Plaintiffs could challenge, and did challenge, such unconstitutional state laws directly under the Supremacy Clause. And nothing in the Supremacy Clause suggests that it may not also be used directly to challenge state laws because they conflict with a federal law, and not (or not just) the federal Constitution. The Supremacy Clause itself provides that both the Constitution "*and* the Laws of the United States which shall be made in Pursuance thereof ... shall be the supreme Law of the Land." U.S. Const. art. VI (emphasis added).

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[11] *Cf. Haywood* v. *Drown*, 129 S. Ct. 2108 (2009) (state courts cannot refuse to entertain certain classes of federal claims); *Howlett ex rel. Howlett* v. *Rose*, 496 U.S. 356 (1990) (state court cannot apply state sovereign-immunity principles to refuse adjudication of federal law claim); *Testa* v. *Katt*, 330 U.S. 386 (1947) (state courts cannot discriminate against federal claims).

Finally, nothing in the Supremacy Clause or this Court's precedent indicates that statutes enacted pursuant to Congress's Spending Clause power should be treated any differently than statutes enacted pursuant to other sources of congressional power, *i.e.*, that direct causes of action may not be brought to vindicate the federal structural interest in the supremacy of Spending Clause statutes. Indeed, numerous Spending Clause statutes—including Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, and the Individuals with Disabilities Education Act—are critical in preventing discrimination and protecting civil liberties, and many others—such as Medicaid and the Supplemental Nutrition Assistance Program (previously called the Food Stamp Program)—provide a critical safety net on which low-income individuals rely for survival.

II. Precluding Direct Rights Of Action Under The Supremacy Clause Would Have Broad And Harmful Consequences For Maintaining The Supremacy Of Federal Law

An action under the Supremacy Clause provides an important—and sometimes the only—avenue to vindicate the supremacy of federal law. Barring a right of action under the Supremacy Clause could effectively foreclose this critical avenue for persons, especially minorities, immigrants, and low-income individuals, who depend on federal law and who would otherwise be subject to invalid state and local laws.

A. Minorities, Immigrants, And Low-Income Individuals Continue To Depend On Direct Actions Under The Supremacy Clause To Challenge Invalid State And Local Laws

Racial minorities, immigrants, and low-income individuals continue to rely directly on the Supremacy Clause to challenge invalid state and local laws in many important areas, including immigration, fair housing, public assistance, and health care. Many of those cases have involved legislation enacted under Congress's Spending Clause power, and the courts have routinely adjudicated and sometimes invalidated state laws that conflicted with the federal legislation.

For example, several plaintiffs in recent years have used the Supremacy Clause to challenge the increasing number of state laws that seek to restrict immigrants' rights, including immigrants' employment opportunities. In *Chamber of Commerce* v. *Edmondson*, 594 F.3d 742 (10th Cir. 2010), plaintiffs claimed that provisions of the Oklahoma Taxpayer and Citizen Protection Act of 2007, which created new employee verification rules and imposed sanctions on employers that allegedly hire undocumented immigrants, conflicted with federal immigration law, which sets forth a comprehensive scheme prohibiting the employment of such individuals. The Tenth Circuit, which upheld in part a preliminary injunction against enforcement of the state law, explained that a "party may bring a claim under the Supremacy Clause that a local enactment is preempted even if the federal law at issue does not create a private right of action." *Id.* at 756 n.13 (internal quotation marks omitted); *see also Chamber of Commerce* v. *Whiting*, 131 S. Ct. 1968 (2011) (adjudicating preemption challenge to Arizona law providing for the revocation or suspension of licenses in certain circumstances

of state employers who knowingly hire undocumented immigrants, but finding no preemption).

Numerous other courts similarly have addressed preemption challenges, under the Supremacy Clause, to state and local laws that affect immigrants' access to housing and other vital services. *See Georgia Latino Alliance for Human Rights* v. *Deal*, No. 11-cv-1804, 2011 WL 2520752, at *6 (N.D. Ga. June 27, 2011) (finding independent jurisdictional grounds under the Supremacy Clause to allow a preemption challenge against Georgia's Illegal Immigration and Enforcement Act of 2011 and entering preliminary injunction); *Buquer* v. *City of Indianapolis*, No. 11-cv-708, 2011 WL 2532935, at *2 (S.D. Ind. June 24, 2011) (considering a Supremacy Clause challenge to an Indiana law that allows, *inter alia*, law enforcement officers to make a warrantless arrest of an immigrant under certain conditions and entering preliminary injunction); *Villas at Parkside Partners* v. *City of Farmers Branch*, 496 F. Supp. 2d 757, 777 (N.D. Tex. 2007) (considering a Supremacy Clause challenge to city ordinance that essentially "created its own classification scheme for determining which noncitizens may rent an apartment" in the city and entering preliminary injunction), *permanent injunction entered*, 577 F. Supp. 2d 858, 879 (2008); *League of United Latin Am. Citizens* v. *Wilson*, 997 F. Supp. 1244 (C.D. Cal. 1997) (finding preempted most provisions of a state law that, *inter alia*, restricted immigrants' access to health care, social services, and education).

Low-income individuals have likewise invoked the Supremacy Clause to ensure compliance with federal housing laws. In *Kemp* v. *Chicago Housing Authority*, No. 10-cv-3347, 2010 WL 2927417 (N.D. Ill. July 21, 2010), a single mother of two argued that municipal

rules unlawfully allowed the Chicago Housing Authority to terminate her public housing assistance in circumstances other than those specified and limited by the United States Housing Act of 1937. Kemp sought to enjoin the local law as preempted under the Supremacy Clause. Although the court ultimately did not grant relief because of the Anti-Injunction Act, it concluded that the Supremacy Clause "create[s] rights enforceable in equity proceedings in federal court," and that it could therefore exercise jurisdiction over Kemp's preemption claim. *Id.* at *3 (internal quotation marks omitted).

Persons receiving public assistance have also invoked the Supremacy Clause to challenge state laws that terminate medical or other benefits in contravention of federal law. For example, in *Comacho* v. *Texas Workforce Commission*, 408 F.3d 229 (5th Cir. 2005), the court invalidated under the Supremacy Clause state regulations that expanded the circumstances, beyond those allowed by federal law, under which Medicaid benefits could be cut off for low-income adults receiving assistance under the federal Temporary Assistance to Needy Families program.

Finally, the Eighth Circuit in *Lankford* v. *Sherman*, 451 F.3d 496 (8th Cir. 2006), relied directly on the Supremacy Clause to preliminarily enjoin a Missouri regulation that limited Medicaid coverage of durable medical equipment to certain populations, making most Medicaid recipients in Missouri ineligible to receive such items even if medically necessary. *Id.* at 509. The court found that the regulation conflicted with Medicaid's requirements and goals and therefore was likely preempted under the Supremacy Clause. *Id.* at 513 (holding that plaintiffs had "established a likelihood

of success on the merits of their preemption claim" for obtaining a preliminary injunction).

The Supremacy Clause right of action therefore remains critically important to minorities, immigrants, and low-income persons in our society who rely on it for vindication of federal law. The availability of that direct action ensures that state and local governments cannot undermine federal law by enacting statutes and regulations that deviate from federal requirements but would, absent a Supremacy Clause action, be effectively insulated from judicial review.

B. Precluding Rights Of Action Under The Supremacy Clause Would Undermine Important Federal Interests

Precluding a right of action under the Supremacy Clause would leave important rights and interests effectively unprotected. Not only will the rights of individual litigants seeking to invalidate unconstitutional state laws be harmed, but important federal supremacy interests could go unprotected as well.

First, precluding rights of action under the Supremacy Clause would leave few, if any, effective remedies to force state compliance with many federal laws that are intended to benefit minorities, immigrants, and low-income persons in our society. In the context of laws enacted under Congress's Spending Clause power, the termination of federal funding may sometimes be theoretically available to remedy the State's failure to comply with its obligations under the Medicaid Act or other Spending Clause laws, *see PhRMA*, 538 U.S. at 675 (Scalia, J., concurring in the judgment), but that remedy is so rare and drastic as to be effectively unavailable as a meaningful enforcement tool. As commentators have explained, both political considerations

and procedural hurdles make withdrawal of federal funding an illusory remedy. *See, e.g.*, Mank, *Suing Under § 1983: The Future After* Gonzaga University v. Doe, 39 Hous. L. Rev. 1417, 1431-1432 (2003) ("[A]s a practical matter, federal agencies rarely invoke the draconian remedy of terminating funding to a state found to have violated the [federal] conditions because there are often lengthy procedural hurdles that allow a state to challenge any proposed termination of funding, and members of Congress from that state will usually oppose termination of funding."); Perkins, *Medicaid: Past Successes and Future Challenges*, 12 Health Matrix 7, 32 (2002) ("[T]he Medicaid Act provides for the Federal Medicaid oversight agency to withdraw federal funding if a State is not complying with the approved State Medicaid plan; however, ... this is a harsh remedy that has rarely, if ever, been followed through to its conclusion."); Key, *Private Enforcement of Federal Funding Conditions Under § 1983: The Supreme Court's Failure to Adhere to the Doctrine of Separation of Powers*, 29 U.C. Davis L. Rev. 283, 292-293 (1996) ("[O]ften the agency's only enforcement mechanism is a cutoff of federal funds for the program[,] ... [which] is rarely, if ever, invoked.").[12]

Moreover, termination of federal funding would in many circumstances be counterproductive and contrary to Congress's intent that the funding program be implemented to provide a wide benefit. Indeed, persons

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[12] As respondents point out (Cal. Pharmacists Br. 2-3, 17), this case shows how difficult it can be for the Executive Branch to enforce the supremacy of federal law by itself; even after the responsible federal agency disapproved state rate cuts as inconsistent with federal law, the State continued to implement its invalid legislation.

who receive crucial benefits and services from federal programs usually do not want federal funding to be terminated. Terminating federal funding would not protect the interests of those injured by the State's noncompliance with federal law; rather, it would harm the very people Congress intended to benefit. *See Cannon* v. *University of Chi.*, 441 U.S. 677, 704-705 (1979) (explaining that "termination of federal financial support for institutions engaged in discriminatory practices ... is ... severe" and "may not provide an appropriate means of accomplishing" the purposes of the statute); *see also* Hills, *Dissecting the State: The Use of Federal Law to Free State and Local Officials from State Legislatures' Control*, 97 Mich. L. Rev. 1201, 1227-1228 (1999) ("[T]he sanction of withdrawing federal funds from noncomplying state or local officials is usually too drastic for the federal government to use with any frequency: withdrawal of funds will injure the very clients that the federal government wishes to serve.").

The more effective way to vindicate the objectives of federal law is to allow for the important role that private parties play in enforcing the supremacy of federal statutes. As the United States previously argued in this case, "those programs in which the drastic measure of withholding all or a major portion of federal funding is the only available remedy would be generally less effective than a system that also permits awards of injunctive relief in private actions in appropriate circumstances." *See* U.S. Cert. Amicus Br. 19. In such circumstances, an injunction would force a State to comply with the federal provision at issue without harming the intended beneficiaries of the federal program.

Nor would it be appropriate to force individuals who depend on federal law to rely exclusively on the federal government to bring affirmative litigation to enforce compliance with the Supremacy Clause. Private rights of action are necessary because the government lacks the resources to police preemption disputes between States and private parties. *See* Sloss, *Constitutional Remedies For Statutory Actions*, 89 Iowa L. Rev. at 404. Private rights of action "increase the social resources devoted to law enforcement, thus complementing government enforcement efforts." Stephenson, *Public Regulation of Private Enforcement: The Case for Expanding the Role of Administrative Agencies*, 91 Va. L. Rev. 93, 108 (2005); *see also Ahlborn*, 547 U.S. at 291. In short, absent a right of action under the Supremacy Clause there could well be no meaningful remedy at all for state noncompliance.[13]

A private right of action under the Supremacy Clause serves other important values as well. The Supremacy Clause supports the structural guarantee of

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[13] Indeed, it is not entirely clear that the federal government would always be authorized to sue to compel enforcement of federal law. Private plaintiffs directly affected by state laws have Article III standing to sue to enjoin their enforcement; the federal government might not. And if private plaintiffs did not have a direct right of action to sue under the Supremacy Clause, it might well be questioned whether the United States could sue without its own statutory cause of action. *Cf. United States* v. *City of Phila.*, 644 F.2d 187 (3d Cir. 1980) (holding that United States may not sue local governments for injunction against violation of Fourteenth Amendment, absent statutory authority to sue). The Court need not resolve those issues in this case, but at a minimum there would be no assurance that enforcement by the United States would necessarily be available if private lawsuits were not permitted.

federalism—namely, that federal law will remain paramount. And that interest can only be effectively vindicated by ensuring that preempted state laws are invalidated—a goal that, for the reasons described above, can best be achieved through a private right of action. In addition, a private right of action, by allowing robust enforcement for preemption claims, fosters uniformity and predictability in the application of both federal and state law.[14] Thus, in order to realize the Constitution's fundamental promise that federal law will remain paramount over invalid state and local laws, it is essential that this Court continue—as it has done for nearly two hundred years—to allow litigants to bring preemption challenges directly under the Supremacy Clause.

CONCLUSION

The judgments of the court of appeals should be affirmed.

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[14] Preemption claims in immigration and other areas of law have also been critical to preserving the federal government's paramount role in foreign policy. *See, e.g.*, *Hines*, 312 U.S. at 63 ("Our system of government is such that the interest of the cities, counties and states, no less than the interest of the people of the whole nation, imperatively requires that federal power in the field affecting foreign relations be left entirely free from local interference."); *id.* at 66-67; *Toll* v. *Moreno*, 458 U.S. 1, 10-13 (1982).

Respectfully submitted.

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RECORD
AND
BRIEFS

Nos. 09-958, 09-1158, and 10-238

In the Supreme Court of the United States

TOBY DOUGLAS, DIRECTOR OF THE DEPARTMENT OF HEALTH CARE SERVICES, STATE OF CALIFORNIA,

v.

INDEPENDENT LIVING CENTER OF SOUTHERN CALIFORNIA, INC., ET AL.

Supreme Court, U.S.
FILED
AUG 5 - 2011
OFFICE OF THE CLERK

TOBY DOUGLAS, DIRECTOR OF THE DEPARTMENT OF HEALTH CARE SERVICES, STATE OF CALIFORNIA, ET AL.

v.

CALIFORNIA PHARMACISTS ASSOCIATION, ET AL.

TOBY DOUGLAS, DIRECTOR OF THE DEPARTMENT OF HEALTH CARE SERVICES, STATE OF CALIFORNIA,

v.

SANTA ROSA MEMORIAL HOSPITAL, ET AL.

ON WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF FOR THE AMERICAN HEALTH CARE ASSOCIATION, AMERICAN HOSPITAL ASSOCIATION, ASSOCIATION OF AMERICAN MEDICAL COLLEGES, CATHOLIC HEALTH ASSOCIATION OF THE UNITED STATES, FEDERATION OF AMERICAN HOSPITALS, NATIONAL ASSOCIATION OF CHILDREN'S HOSPITALS, NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS, NATIONAL ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS, NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE, AND SAFETY NET HOSPITALS FOR PHARMACEUTICAL ACCESS AS AMICI CURIAE IN SUPPORT OF RESPONDENTS

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INTEREST OF AMICI[1]

Amici are the American Health Care Association, the American Hospital Association, the Association of American Medical Colleges, the Catholic Health Association of the United States, the Federation of American Hospitals, the National Association of Children's Hospitals, the National Association of Community Health Centers, the National Association of Public Hospitals and Health Systems, the National Council for Community Behavioral Healthcare, and Safety Net Hospitals for Pharmaceutical Access.[2] Amici include associations and networks of hospitals, health systems, and other healthcare providers and collectively represent over 20,000 facilities, in addition to more than one hundred thousand individual practitioners, who supply critically needed medical services to millions of Americans throughout the nation. Amici share a strong interest in the proper administration and enforcement of the statutory requirements of the Medicaid Act.

As Medicaid providers, members of our organizations are acutely aware of the difficulties Medicaid recipients face when seeking primary, secondary, and tertiary care. Despite a continued commitment to treating the Medicaid population, increased Medicaid volume at

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[1] The parties have consented to the filing of this brief in letters on file with the Clerk. No counsel for any party authored this brief in whole or in part, and no person or entity, other than amici curiae, their members, or their counsel, made a monetary contribution intended to fund the preparation or submission of this brief.

[2] A short description of each of the amici organizations is included in an appendix hereto.

reduced rates threatens our organizations' members' long-term financial viability and ability to adequately serve Medicaid recipients.

The Supremacy Clause of the Constitution plays a critical part in the system of structural federalism adopted by the Founders. Provider suits such as those brought by respondents vindicate the primacy of federal law by ensuring that the Medicaid Act is not undermined or subverted by conflicting state law, and that the Medicaid program serves Congress's purpose of providing meaningful benefits to Medicaid recipients. Accordingly, amici curiae and their members have a substantial interest in the important issues raised in these cases.

INTRODUCTION AND SUMMARY

Petitioners ask the Court to hold that Medicaid providers are powerless to stop California from enforcing against them drastic cuts in Medicaid payment rates that violate the mandates of federal law. As these cases come to the Court, it is taken as a given that California's indiscriminate, across-the-board 10% cut in rates, without any consideration of the impact of those cuts on beneficiaries' access to care, violates the Medicaid Act. It is also established that respondents, Medicaid providers, are directly and substantially injured by these cuts, which further reduce payment rates that are, for many providers, already significantly below the cost of providing care. Finally, it is established that the administrative review process is singularly ineffective at vindicating the supremacy of federal law. In fact, petitioners have essentially disregarded the administrative process for more than two years, and simply ignored the federal oversight agency when it rejected

California's plan amendment as unsupported by any evidence. Petitioners nonetheless contend that, even assuming all of this, Medicaid providers have no cause of action under the Supremacy Clause to seek a declaration that the cuts are invalid and an injunction preventing their enforcement against providers. Petitioners are wrong.

1. The Medicaid program is responsible for providing access to medical care for more than a quarter of the population of the United States and one third of all children, a percentage that is likely to grow even higher. One of the central requirements of any state Medicaid program is that the program must ensure access for beneficiaries to medical services equal to the access enjoyed by the general population.

Dramatic, indiscriminate cuts of the type at issue in these cases pose a serious threat to an already overtaxed safety net for our most vulnerable citizens, including millions of seniors, children, pregnant women and people with disabilities. Hospitals and nursing homes already are paid by Medicaid programs at rates far below their costs. Hospitals, on average, are compensated at rates 15% less than their costs, and nursing home facilities, on average, are paid at rates almost 10% below provider costs. As a result, providers have been forced to forgo new initiatives and in some cases cease providing certain services. Low reimbursement rates have caused large numbers of doctors to withdraw from the program, with adverse consequences for the entire safety net. It has, for example, become increasingly difficult for Medicaid beneficiaries to find a physician, especially a specialist. Medicaid beneficiaries have difficulty obtaining specialty consultations at an alarming rate, roughly three times more often than

insured patients. And, as access to physicians becomes more difficult, patients turn to hospital emergency departments, an inefficient use of resources that only adds additional pressure to an already over-taxed system.

Multiple courts of appeals have held that across-the-board rate cuts, adopted for purely budgetary reasons and without considering their effect on quality, efficiency, or the availability of care for beneficiaries, are precluded by the Medicaid Act. Lawsuits brought under the Supremacy Clause are the only effective way to prevent states from implementing illegal rate cuts.

The system of administrative oversight by the Department of Health and Human Services ("HHS") is, by constrast, structurally incapable of preventing states from acting in derogation of Medicaid's equal access requirement. Limited to what information the state provides it, HHS is ill-equipped to serve as an independent check against violations of the federal mandate. Nor, when a violation is identified, does HHS have an effective way to bring the state into compliance. The present case, in which petitioners simply ignored the federal administrative proceeding, and continued to implement California's rate cuts even after the proposed state plan amendment was rejected, demonstrates the inadequacy of the administrative scheme.

Without the ability to bring a suit for declaratory and injunctive relief under the Supremacy Clause, respondents would have no avenue for relief, but would instead simply have to endure California's illegal rate cuts.

2. This Court has repeatedly recognized that "the availability of prospective relief of the sort awarded in

Ex parte Young gives life to the Supremacy Clause. Remedies designed to end a continuing violation of federal law are necessary to vindicate the federal interest in assuring the supremacy of that law." *Green* v. *Mansour*, 474 U.S. 64, 68 (1985). Petitioners acknowledge the numerous cases in which this Court has entertained a Supremacy Clause challenge and do not genuinely dispute that there are many circumstances in which such a cause of action exists. *See* Pet. Br. 42-44. Petitioners spend most of their brief arguing instead that such a cause of action should not be recognized in the specific context of a suit to set aside a state law that is invalid because it conflicts with 42 U.S.C. 1396a(a)(30)(A) ("Section 30(A)"). Those arguments are mistaken.

There is no basis for petitioners' contention that a Supremacy Clause challenge is inappropriate in the Section 30(A) context because Congress did not create a separate statutory cause of action "to enforce" Medicaid or confer privately enforceable "individual rights." Pet. Br. 20, 25. The absence of a separate statutory cause of action is of no moment because a plaintiff asserting a cause of action under the Supremacy Clause does not seek to "enforce" the statute. Such a suit does not afford affirmative relief, such as an injunction directing the defendant to take an affirmative act, or retrospective relief, such as damages. Rather, a Supremacy Clause challenge is limited to vindicating the primacy of federal law over inconsistent state law through a declaration that the state law is invalid and an injunction against its enforcement.

The preemptive effect of federal law under the Supremacy Clause does not depend upon Congress having created a cause of action against the state. Congress

need not specify a statute's preemptive effect at all. Indeed, state law can be invalid under the Supremacy Clause even in the absence of congressional legislation. In *American Insurance Ass'n* v. *Garamendi*, 539 U.S. 369 (2003), for example, an executive agreement was held to preempt a California statute purporting to regulate conduct relating to Holocaust-era insurance policies. *Id.* at 419-420. See also *Zschernig* v. *Miller*, 389 U.S. 431, 441 (1968) (state law interfering with foreign policy can be preempted "even in the absence of a treaty"). And a preemptive federal statute may be directed at private parties, or even federal officials, rather than at the state. See, *e.g.*, *Crosby* v. *Nat'l Foreign Trade Council*, 530 U.S. 363, 388 (2000) (statute authorizing President to adopt calibrated sanctions policy against Burmese regime preempted state secondary boycott of companies doing business with Burma). In such circumstances, one would hardly expect Congress to create a private cause of action against the state solely on the off-chance a state enacted legislation to frustrate the federal scheme.

Petitioners' other arguments also fail to justify refusing to recognize a Supremacy Clause cause of action in this case. There is no basis for petitioners' assertion that the Supremacy Clause can only be vindicated by parties who are "regulated" by the invalid state statute. Pet. Br. 43. In *Crosby*, for example, Massachusetts' policy of not contracting with companies doing business in Burma could not be "enforced" against private entities, yet companies that were ineligible to receive state contracts were permitted to bring a Supremacy Clause challenge to the state statute. To the extent that being "regulated" is an essential prerequisite, Medicaid providers are unquestionably at least as regu-

lated as (if not more than) other businesses that have brought successful Supremacy Clause challenges before this Court. Providers thus plainly have a sufficiently direct injury from California's rate cuts to confer standing. Precluding such directly injured parties from bringing a Supremacy Clause challenge would be inconsistent with this Court's recognition that "[a]n individual has a direct interest in objecting to laws that upset the constitutional balance between the National Government and the States when enforcement of those laws causes injury that is concrete, particular, and redressable." *Bond* v. *United States*, 131 S. Ct. 2355, 2364 (2011).

Nor does the fact that Medicaid was enacted under Congress's Spending Clause power diminish its preemptive effect. And, finally, contrary to petitioners' suggestion, Congress has not impliedly precluded a Supremacy Clause cause of action by creating an administrative remedy to enforce Section 30(A) that must be exclusive in order to be effective. Indeed, the administrative process for overseeing state Medicaid programs is structurally incapable of preventing states from violating Section 30(A).

I. SUPREMACY CLAUSE CHALLENGES PLAY A CRITICAL ROLE IN VINDICATING THE PRIMACY OF THE MEDICAID ACT OVER INCONSISTENT STATE LAWS

Congress's purpose in establishing the Medicaid program, codified in Title XIX of the Social Security Act ("SSA"), 42 U.S.C. 1396 *et seq.*, was to provide comprehensive health benefits to "the most needy in the country." *Schweiker* v. *Hogan*, 457 U.S. 569, 590 (1982) (quoting H.R. Rep. No. 213, 89th Cong., 1st

Sess., 66 (1965)). While originally targeting limited subsets of individuals in particularly difficult circumstances, Medicaid was gradually expanded to protect additional populations unable to secure insurance in the private market. Many beneficiaries are unable to work, and those who can are often unable to secure private, employer-sponsored insurance. See Medicaid and CHIP Payment and Access Commission ("MACPAC"), Report to the Congress on Medicaid and CHIP 10 (2011) (the "MACPAC Report"). Today, Medicaid (along with the Children's Health Insurance Program ("CHIP")) provide coverage for 75 million beneficiaries—constituting more than a quarter of the population of the United States and one-third of all children—who otherwise would likely have no health care coverage at all. *Id* at 17, 75. That figure is likely to grow even larger in the future. See, *e.g.*, Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

Medicaid's beneficiaries rely on the program to guarantee them access to critical medical services, including preventive health checkups, specialist consultations, mental health counseling, and nursing home care. These 68 million people benefit from Medicaid, but only to the extent that it offers meaningful access to health care services.

As the court of appeals concluded—in a holding that this Court declined to review, and that therefore provides the basic premise of this proceeding—California's imposition of indiscriminate reductions of as much as 10 percent to Medicaid rates that were already below many providers' costs was inconsistent with the federal statutory requirements by which Congress sought to ensure adequate access to medical care for Medicaid beneficiaries. Whether Title XIX is con-

strued as establishing procedural requirements or substantive ones, California's across-the-board cuts based purely on state budgetary considerations violated the federal statutory scheme. Indeed, although "the State's own Legislative Analyst warned that the ten percent rate reduction had 'the potential to negatively impact the operation of the Medi-Cal Program and the services provided to beneficiaries by limiting access to providers and services,'" no state official even *considered* what impact the cuts might have on accessibility. *Independent Living Center* v. *Maxwell-Jolly*, 572 F.3d 644, 656 (9th Cir. 2009). Predictably, the cuts did "force[] at least some providers to stop treating Medi-Cal beneficiaries." *Id.* at 657.

A decision in favor of petitioner would allow not only California, but all states, to defy federal law with virtual impunity. Indeed, in the absence of a Supremacy Clause challenge, states will be emboldened to enforce their invalid laws against individuals and businesses who are directly injured thereby. Those injured parties will have no avenue by which to vindicate the supremacy of federal law over inconsistent state policy. Where, as here, the state disregards the requirements of Medicaid, it is the Nation's most vulnerable citizens, including millions of seniors, children, pregnant women and people with disabilities, who will suffer most.

A. Congress Required States To Set Medicaid Payment Rates In A Manner That Would Ensure Adequate Access To Health Care For Medicaid Beneficiaries

While Congress gave states a choice whether to establish a Medicaid program, if a state chooses to do so—and to accept the associated federal financial support—

it must comply with the federal requirements for the program set forth in Title XIX and implementing regulations. For those states that choose to participate in Medicaid, Congress specified those requirements that the state's "plan for medical assistance *must*" satisfy. 42 U.S.C. 1396a(a) (emphasis added).

A central requirement of Title XIX is that each state program offer meaningful medical benefits to its Medicaid beneficiaries. Title XIX lists specific services that any participating state Medicaid program "must" make available to beneficiaries, which include inpatient and outpatient hospital services, laboratory and x-ray services, nursing facility services to beneficiaries aged 21 or older, and physician services. 42 U.S.C. 1396a(a)(10), 1396d(a)(1)-(5), (17), (21). States are prohibited from limiting access to these services unless and until they receive explicit permission from HHS through a waiver. See 42 U.S.C. 1315(a), 1396n.

Congress recognized that meaningful access to these mandated services requires adequate access to health care providers. To assure such access, Congress further required that participating state programs

> must * * * provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan * * * to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.

42 U.S.C. 1396a(a)(30)(A). Section 30(A) reflects Congress's specific and expressed intent to "assure" that "care and services are available" to Medicaid beneficiaries "at least to the extent that such care and services are available to the general population." *Ibid.*

Moreover, Section 30(A) expressly links the statutory requirement of available services to the level of payments that state programs offer providers. Because state programs do not generally provide services directly, Congress required that the state's program ensure that "payments * * * are sufficient to enlist enough providers" to make services available at a level equal to that of the general population. 42 U.S.C. 1396a(a)(30)(A). See also H.R. Rep. No. 101-247, at 2116 (1989) (noting that the expanded Section 30(A) codified a regulatory standard "requiring adequate payment levels").[3]

B. Reduced Payment Rates Threaten The Already Fragile System For Delivering The Level Of Services Mandated By Congress

A Medicaid program's ability to provide adequate access to services as required by Congress depends upon its paying rates that are adequate to attract providers. States generally do not provide Medicaid bene-

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[3] Petitioners cite Congress's repeal of the "Boren Amendment" of Title XIX as evidence that Congress regards private suits challenging the adequacy of Medicaid payments as "antithetical" to States' flexibility in administering Medicaid. Pet. Br. 31. Petitioners are incorrect, as the repeal of the Boren Amendment in 1997 had no implications for suits to vindicate Section 30(A). See Br. of Intervenor Resp. in No. 09-958 and California Pharmacists Resp. in No. 09-1158, at 57-59.

fits directly to program beneficiaries. Instead, states contract with health care providers—physicians, dentists, hospitals, clinics, mental health centers, nursing homes, home health agencies and others—to provide them.

Medicaid payments, however, are often well below the levels needed to sustain an adequate provider network. Hospital and nursing home rates, for example, not only lag behind payments offered by Medicare and commercial payers for similar services, but also fall far short of provider costs. The hospital industry has found Medicaid margins to be on average almost *15 percent lower than hospital costs.* See Milliman, Hospital & Physician Cost Shift: Patient Level Comparison of Medicare, Medicaid, and Commercial Payers 6 (Dec. 2008). Children's hospitals experience an even greater shortfall, with Medicaid on average paying only 77 percent of their costs. National Association of Children's Hospitals and Related Institutions, FY 2009 Annual Survey on Utilization and Financial Indicators of Children's Hospitals (2009). Base payments to public hospitals on average are only 76 percent of hospital costs. And although public hospitals often have access to additional Medicaid payments to support their public missions, over 40 percent still report a loss on providing Medicaid care. National Association of Public Hospitals and Health Systems, America's Public Hospitals and Health Systems, 2009 Results of the Annual NAPH Hospital Characteristics Survey 13-14 (2010). The nursing home industry similarly has found that Medicaid pays only 91 percent of provider costs. See Eljay LLC, A Report on Shortfalls in Medicaid Funding for Nursing Home Care 2 (2010). The same study calculated that, on average, nursing homes lose $17.33 per-

Medicaid patient, per-day. See *ibid.* In other words, most providers lose money for each Medicaid beneficiary that they treat.

Unchecked, and increasingly common, reductions in Medicaid payment rates to institutional providers pose a direct threat to beneficiaries' access to medical services. Many initiatives that would improve beneficiary access to care have gone unimplemented, with hospitals concluding that high Medicaid volumes, coupled with below-cost reimbursement rates, would make these initiatives financially unsustainable. See The Lewin Group, Analysis of Medicaid Reimbursement in Oregon 44-45 (2003). Existing services have, in some cases, been discontinued for the same reason. In one highly publicized case, a hospital in Clare, Michigan, shuttered its obstetrical unit in direct response to the state's inadequate Medicaid payments. See Kevin Sack, *As Medicaid Payments Shrink, Patients are Abandoned*, N.Y. Times, March 15, 2010. The state program reimbursed only 65 percent of hospital costs. *Ibid.*

Lowering payment rates for physicians likewise presents a direct threat to Medicaid beneficiaries' access to such services. Ample evidence, including government reports, demonstrates that low reimbursement rates have led many physicians, and particularly specialists, to stop treating Medicaid patients. For example, while 79 percent of physicians participating in the Medicaid and CHIP accept all privately-insured children as new patients, less than half—only 47 percent—accept all new patients covered by Medicaid or CHIP. See U.S. Government Accountability Office, Medicaid and CHIP: Most Physicians Serve Covered Children but Have Difficulty Referring Them for

Specialty Care, GAO-11-624, at 11 (2011) ("GAO Report"). Even more troubling, another survey found that almost half of office-based physicians had difficultly referring Medicaid patients for specialty consultations, more than three times the rate of difficulty experienced in referring privately insured patients for those same services. See MACPAC Report at 132.

Physicians already cite inadequate payment as the most common reason for not accepting Medicaid patients. MACPAC Report at 132. Among physicians who do not serve Medicaid/CHIP children, 95% cited low reimbursement rates as influencing their decision. See GAO Report at 18; see also Kaiser Commission on Medicaid and the Uninsured, Physician Willingness and Resources to Serve More Medicaid patients: Perspectives from Primary Care Physicians 3 (2011) (noting that almost 90 percent of primary care practitioners who accept no or only some new Medicaid patients cite inadequate reimbursement as a reason for their decision not to participate).

Beyond the direct impact on the availability of physician services, inadequate payment rates for doctors also have the indirect effect of shifting the cost of Medicaid services to hospitals, whose resources are already strained. With shrinking access to office-based specialty care, many Medicaid beneficiaries turn to hospital emergency departments for this care. California HealthCare Foundation, Issue Brief: Overuse of Emergency Departments Among Insured Californians (2006); Peter J. Cunningham & Len M. Nichols, *The Effects of Medicaid Reimbursement on the Access to Care of Medicaid Enrollees: A Community Perspective*, 62 Med. Care Research & Rev. 676, 691 (2005). Because providing services at hospital emergency rooms is more

costly than at doctors' offices,[4] indiscriminately reducing payments to doctors results in a net reduction in efficiency for the Medicaid program.

C. State "Flexibility" In Administering The Medicaid Program Does Not Extend To Reducing Beneficiary Access In Response To Budgetary Shortfalls

Medicaid's federal-state partnership structure offers states significant flexibility in establishing delivery systems, developing payment methodologies, and setting payment rates. While this flexibility is intended to allow states to achieve the "best value" from their Medicaid programs, see 76 Fed. Reg. 26342, 26343 (May 6, 2011), states have instead repeatedly invoked this "flexibility" as an excuse to use Medicaid rate cuts to balance their budgets, resulting in undermining efficiency without improving quality, the two benchmarks by which "value" is generally assessed. See, *e.g.*, U.S. Government Accountability Office, Value in Health Care: Key Information for Policymakers to Assess Efforts to Improve Quality While Reducing Costs, GAO-11-445, at 2 (2011).

Multiple federal courts have found that Section 30(A) prohibits indiscriminate cuts to Medicaid payments in response to budgetary pressure. The Ninth Circuit found that California had failed to consider the potential impact of its 2008 and 2009 Medicaid rate cuts on efficiency, economy, quality, or access to care, and

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[4] See Linda C. Baker & Laurence S. Baker, *Excess Cost of Emergency Department Visits for Nonurgent Care*, 13 Health Affairs 162 (Nov. 1994).

the court therefore set aside the legislation as preempted by Section 30(A). See *Independent Living Center*, 572 F.3d at 652. Other courts have reached similar conclusions. The Eighth Circuit has likewise held that Section 30(A) "mandates consideration of the equal access factors of efficiency, economy, quality of care and access to services in the process of setting or changing payment rates," and that a state therefore cannot make indiscriminate payment cuts based on budgetary grounds alone. *Minn. Homecare Ass'n* v. *Gomez*, 108 F.3d 917, 918 (1997). See also *Amisub (PSL), Inc.* v. *Col. Dep't of Soc. Services*, 879 F.2d 789, 800 (10th Cir. 1989), cert. denied 496 U.S. 935 (1990) ("[B]udgetary constraints cannot excuse noncompliance with federal Medicaid law."); *Kan. Hosp. Ass'n* v. *Whiteman*, 835 F. Supp. 1556, 1570-1571 (D. Kan. 1993) (holding that, where "the significant increase in the co-pay requirement is proposed solely because of its budgetary impact in favor of the state, without considering the other factors listed in the statute, the amendment would appear to violate 42 U.S.C. § 1396a(a)(30)(A)").

D. Absent Supremacy Clause Suits, States Will Continue Making Indiscriminate Rate Cuts, Thus Threatening Medicaid's Ability To Serve Its Congressional Purpose

Although it is well established that Congress prohibited states from simply slashing their rates in an indiscriminate fashion in order to close a budget gap, in the absence of Supremacy Clause challenges, states will remain largely free to do so. The system of federal administrative oversight is simply inadequate to protect the Medicaid Act from such state infringement. Although states must submit plans and any amendments to those plans for approval by the Centers for Medicare

and Medicaid Services ("CMS"), which administers the Medicaid program within HHS, CMS lacks the information necessary to assess the impacts of state plan amendments ("SPAs") on access to care. And the sole federal remedy once a violation is detected—withholding federal funds—is so unpalatable that states can largely ignore the federal administrative process, as petitioners have done here. Supremacy Clause challenges provide an essential mechanism for ensuring that states are not implementing Medicaid policies that are contrary to superior federal law.

1. CMS Lacks The Information That Would Be Necessary To Assess State Compliance With Section 30(A)

No formal processes currently exist by which CMS can assess the adequacy of beneficiary access to Medicaid services. To the extent CMS reviews access at all, it does so informally, in the process of reviewing an SPA. Any review in that context, however, must rely entirely on information submitted by the state, because the SPA approval process affords beneficiaries and providers no meaningful role or redress.

The administrative review process affords CMS little opportunity to gather any reliable information about the extent of beneficiaries' access to health services. While CMS requires that states provide public notice of proposed changes to payment methodologies, states need not solicit or incorporate public comments in response to this notice. 42 C.F.R. 447.205. Once an SPA is submitted, negotiations occur exclusively and privately between CMS and the state, and most disputes between CMS and the state are resolved during these negotiations. Providers have no express opportunity

for input unless CMS *denies* a SPA and the state appeals that denial to the Secretary of HHS. 42 C.F.R. 430.18. At that point, providers can seek to be recognized as parties to the hearing or to participate as amici, 42 C.F.R. 430.76, but the rarity of reconsideration requests renders provider participation virtually nonexistent.[5] Moreover, because SPA reviews relating to payment cuts arise only when a state seeks CMS permission for those cuts, the state lacks any incentive to provide transparent and objective information demonstrating the full impact of those cuts on beneficiaries' access to care.[6]

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[5] Since June 1, 2009, CMS has approved 640 SPAs. Centers for Medicare & Medicaid Services, Medicaid State Plan Amendments, https://www.cms.gov/MedicaidGenInfo/StatePlan/list.asp (accessed July 11, 2011). During that same period, there have only been four requests for reconsideration. 74 Fed. Reg. 29703 (June 23, 2009); 75 Fed. Reg. 80058 (Dec. 21, 2010); 76 Fed. Reg. 34711 (June 14, 2011); 76 Fed. Reg. 44591 (July 26, 2011).

[6] After the Court granted certiorari in these cases, CMS issued proposed regulations to create a process by which states could demonstrate compliance with Section 30(A). 76 Fed. Reg. 26342 (May 6, 2011). These proposed regulations have been widely criticized as representing little improvement over the current SPA approval process. See Sara Rosenbaum, *Medicaid and Access to Health Care – A Proposal for Continued Inaction?*, 365 New Engl. J. Med. 102-104 (July 14, 2011). Regardless of their final form, the new regulations cannot obviate the need for a judicial remedy against state laws that violate the Medicaid Act. CMS cannot, through administrative rulemaking, give itself the power to enjoin state laws that conflict with the Medicaid Act. And, as described below, judicial injunctions against preempted state laws are the *only* effective means of vindicating the supremacy of the Medicaid Act.

2. Federal Injunctive Relief Provides A Necessary Complement To HHS's Enforcement Powers

CMS's enforcement powers are structurally inadequate to ensure state compliance with Section 30(A). To the extent CMS identifies a violation, its sole remedy is the disallowance process. Under this authority, CMS may withhold or limit Medicaid support to that state until the agency is satisfied that the program is and will continue to be compliant. 42 U.S.C. 1396c; 42 C.F.R. 430.35. However, CMS's decision to withhold federal funds, either in part or in full, is fraught with potentially adverse consequences. Such action is counterproductive from a practical perspective; the lack of federal funds would likely leave states unable to pay providers, causing providers to stop treating Medicaid beneficiaries and further exacerbating the access problem. Moreover, CMS almost certainly would be subject to acute political pressure, both from the state itself and its Congressional delegation, should it even threaten to withhold funds. Withholding funds is an extraordinary remedy to be used only in the most extreme instances of non-compliance. It is inappropriate, and likely ineffective, for disputes of a lesser magnitude.

California's 2008 and 2009 payment cuts demonstrate the limitations of HHS's enforcement powers and the essential role played by federal courts in vindicating the requirements of Section 30(A). In September 2008, after these cuts were enacted, they were submitted for CMS approval through the SPA process. See Br. of Intervenor Resp. in No. 09-958 and California Pharmacists Resp. in No. 09-1158, at 6. Within 90 days, CMS informed California that CMS could not approve the cuts because the state had provided inade-

quate information to demonstrate that the cuts would not violate federal Medicaid requirements. *Ibid.* California, however, simply ignored CMS's request for further information. *Ibid.* Finally, on November 18, 2010, over two years after California had implemented its rate cuts, CMS denied the SPAs for lack of adequate information. U.S. Cert. Amicus Br. 7. Throughout this period, while the state was simply ignoring CMS's administrative review, and even after CMS had denied approval of the SPAs, California *persisted* in paying providers at the reduced rate except where the reduced rate was specifically enjoined by the federal courts. Br. of Intervenor Resp. in No. 09-958 and California Pharmacists Resp. in No. 09-1158, at 5. The only cuts that California did not unilaterally implement were those that had been enjoined in actions brought under the Supremacy Clause.

A similar situation recently arose in Indiana, with the state once again ignoring CMS's disapproval of an SPA. The Indiana legislature had passed legislation prohibiting providers that furnish abortion services from participating in the Medicaid program. This provision went into effect on May 10, 2011. Implementing this provision immediately, Indiana then sought CMS approval through the SPA process. CMS disapproved the SPA on June 1, 2011, explaining that the Indiana law violated the Medicaid Act. Despite this disapproval, Indiana continued enforcing the legislation and CMS undertook no enforcement activities. The policy was not reversed until June 24, 2011, when the United States District Court for the Southern District of Indiana enjoined further enforcement. See Entry on Mot. For Prelim. Inj., No. 1:11-cv-630-TWP-TAB (S.D. Ind. June 24, 2011).

As these examples demonstrate, without an available cause of action under the Supremacy Clause, states would be free to adopt and enforce against providers rate cuts that are precluded by federal law.

II. THERE IS NO BASIS TO CONCLUDE THAT A SUPREMACY CLAUSE CHALLENGE IS PARTICULARLY INAPPROPRIATE IN THE MEDICAID CONTEXT

From its earliest cases, this Court has recognized that "plaintiffs may vindicate [statutory] preemption claims by seeking declaratory and equitable relief in the federal district courts through their powers under federal jurisdictional statutes." *Golden State Transit Corp.* v. *City of Los Angeles*, 493 U.S. 103, 119 (1989) (Kennedy, J., dissenting); *id.* at 113-114 (collecting cases so holding). And, as the Solicitor General recognizes, the Court has "decided dozens of preemption claims against state officials on the merits," U.S. Br. 17, on the premise that "[a] plaintiff who seeks injunctive relief from state regulation, on the ground that such regulation is pre-empted by a federal statute which, by virtue of the Supremacy Clause of the Constitution, must prevail, * * * presents a federal question which the federal courts have jurisdiction under 28 U.S.C. § 1331 to resolve." *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 96 n.14 (1983). Implicitly acknowledging the strength of that precedent, much of petitioners' brief, like that of the Solicitor General, assumes the availability of a cause of action under the Supremacy Clause in most circumstances, and instead argues that such a cause of action should not be recognized in the specific context of a suit to set aside a state law that is invalid because it conflicts with Section 30(A).

There is no basis, however, for petitioners' contention that a Supremacy Clause challenge is particularly inappropriate in the Medicaid context generally, or the Section 30(A) context specifically. Petitioners' argument that Congress did not create a statutory cause of action to enforce Medicaid is inapposite. Unlike a statutory cause of action or one under Section 1983, a cause of action under the Supremacy Clause does not allow a plaintiff to seek retrospective or affirmative relief, such as damages or an injunction directing the defendant to take some affirmative action. Rather, relief is limited to a declaration that the state law is invalid and an injunction against its enforcement. Moreover, the Supremacy Clause renders invalid state statutes that conflict with federal law even in circumstances where Congress would not be expected to have created a cause of action against the state. For example, state laws can be preempted even in the absence of any federal statute, or where the federal legislation, if there is any, is directed at private parties, or even federal officials, rather than at the state.

Nor do petitioners' other arguments justify refusing to recognize a Supremacy Clause cause of action in this case. This Courts' cases do not support petitioners' contention that the Supremacy Clause can only be vindicated by parties who are "regulated" by the invalid state statute. Pet. Br. 43. But, if being regulated is a necessary prerequisite, Medicaid providers are easily as regulated as other businesses that have successfully brought Supremacy Clause challenges before this Court. Nor does the fact that Medicaid was enacted under Congress's Spending Clause power diminish its preemptive effect. And, finally, contrary to petitioners' suggestion, the administrative review process for state

plans does not reflect a congressional intent to preclude other remedies against state laws that violate Section 30(A).

A. The Availability Of A Supremacy Clause Challenge Does Not Depend On Whether The Medicaid Act Creates A Cause Of Action Or An Individually Enforceable Right

While petitioners expend numerous pages seeking to prove that Congress did not provide for a statutory cause of action in the Medicaid Act itself (Pet. Br. 20-26), that question is beside the point. This Court has consistently held that "the existence of conflict cognizable under the Supremacy Clause does not depend on express congressional recognition that federal and state law may conflict." *Crosby* v. *Nat'l Foreign Trade Council*, 530 U.S. 363, 388 (2000). No statutory cause of action is necessary because the foundational decision in *Ex parte Young*, 209 U.S. 123 (1908), established the authority of federal courts to "vindicate federal rights and hold state officials responsible to 'the supreme authority of the United States.'" *Pennhurst State School & Hosp.* v. *Halderman*, 465 U.S. 89, 105 (1984). See *Alden* v. *Maine*, 527 U.S. 706, 755, 757 (1999).

In *Shaw*, for example, the Court upheld the federal courts' authority to grant the plaintiff relief in a Supremacy Clause challenge, despite the absence of a cause of action derived from the preemptive federal statute. The Court noted that it "frequently has resolved pre-emption disputes in a similar jurisdictional posture." 463 U.S. at 96 n.14. More recently, in *Verizon Maryland, Inc.* v. *Pub. Serv. Comm'n of Maryland*, 535 U.S. 635 (2002), the Court rejected the assertion that a district court could not reach the merits of a

preemption claim unless the plaintiff had demonstrated a statutory cause of action.

Petitioners' suggestion (Pet. Br. 33) that recognition of a Supremacy Clause cause of action would permit an "end-run" around *Alexander* v. *Sandoval*, 532 U.S. 275 (2001), and *Cort* v. *Ash*, 422 U.S. 66 (1975), is mistaken. Petitioners' arguments ignore the critical distinctions between a cause of action for affirmative relief to enforce a federal right, and a suit challenging a state statute under the Supremacy Clause, which merely asks the court to set aside and enjoin enforcement of the invalid state law. "[T]he availability of prospective relief of the sort awarded in *Ex parte Young* gives life to the Supremacy Clause. Remedies designed to end a continuing violation of federal law are necessary to vindicate the federal interest in assuring the supremacy of that law." *Green* v. *Mansour*, 474 U.S. 64, 68 (1985). Indeed, in several decisions in which the Court has held a damages remedy unavailable against a state, the Court has stressed that denying a damages remedy "strikes the proper balance between the supremacy of federal law and the separate sovereignty of the States" precisely because *Ex parte Young* and similar "[e]stablished rules provide ample means to correct ongoing violations of law and to vindicate the interests which animate the Supremacy Clause." *Alden*, 527 U.S. at 757. Here, by contrast, if respondents are denied a cause of action under the Supremacy Clause, there will be no effective "means to vindicate" the primacy of federal law over a conflicting state statute.

Petitioners' focus on the purported absence of a statutory "right" under Medicaid enforceable under Section 1983 is similarly misplaced. "[Section] 1983 does not provide the exclusive relief that the federal

courts have to offer." *Golden State Transit Corp.*, 493 U.S. at 119 (Kennedy, J., dissenting). Indeed, this Court has consistently upheld Supremacy Clause challenges without relying on either Section 1983, or the preemptive federal statute to establish a cause of action. See, *e.g.*, *Crosby*, 530 U.S. at 363; *United States* v. *Locke*, 529 U.S. 89 (2000); *Gade* v. *Nat'l Solid Waste mgmt. Ass'n*, 505 U.S. 88 (1992); *Lawrence County* v. *Lead-Deadwood Sch. Dist.*, 469 U.S. 256 (1985); *Capital Cities* v. *Crisp*, 467 U.S. 691 (1984).[7]

In the Medicaid context itself, the Court has addressed preemption claims in numerous cases in which there was no individually enforceable right or statutory cause of action. In *Pharm. Research & Mfrs. of Am.* v. *Walsh*, for example, an association of drug manufacturers challenged the constitutionality of Maine's prescription drug rebate program. 538 U.S. 644, 650 (2003). All seven Justices agreed that the Supremacy Clause provided a preemption claim to challenge a state law as

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[7] The Solicitor General's brief discusses two cases that it claims demonstrate that "the Court clearly viewed Section 1983 as the sole source of a private right of action to enforce statutory provisions governing joint federal-state programs under the SSA." U.S. Br. 29-30 (discussing *Maine* v. *Thiboutot*, 448 U.S. 1 (1980) and *Suter* v. *Artist M.*, 503 U.S. 347 (1992)). In each of those cases, however, the plaintiffs sought affirmative relief that could not have been provided by a cause of action under the Supremacy Clause alone. See *Suter*, 503 U.S. at 353 (noting district court's "injunction requiring petitioners to assign a caseworker to each child placed in DCFS custody within three working days of the time the case is first heard in Juvenile Court"); *Thiboutot*, 448 U.S. at 3 (noting that the Superior Court had "ordered [petitioners] to adopt new regulations * * * and to pay the correct amounts retroactively to respondents").

invalid under the Medicaid Act. *Id.* at 667-668. See also *Ark. Dep't. of Health & Human Servs.* v. *Ahlborn*, 547 U.S. 268, 274, 292 (2006) (Medicaid Act preempted ADHS' assertion of a claim against proceeds that a beneficiary received from a personal injury settlement).

Petitioners' argument that a Supremacy Clause challenge is unavailable whenever Congress has failed to provide a statutory cause of action or "right" is particularly misplaced in light of the fact that state law can be preempted under the Supremacy Clause even in the absence of federal legislation. In *American Insurance Ass'n* v. *Garamendi*, for example, the Court upheld a Supremacy Clause challenge based on conflict between a state law and federal foreign policy reflected in Executive Agreements. 539 U.S. 396, 419-420 (2003). See also *Zschernig* v. *Miller*, 389 U.S. 431, 441 (1968) (holding that "[w]here [state] laws conflict with a treaty, they must bow to the superior federal policy. Yet, even in the absence of a treaty, a State's policy may disturb foreign relations."). Because federal "law" that is not enacted by Congress can preempt inconsistent state policy, it would be incongruous to require a congressionally enacted private right of action in order to vindicate that preemptive federal policy.

Even where Congress has itself enacted the preemptive law in question, it may have had no occasion to consider whether to create a cause of action to challenge a conflicting state law. In *Crosby*, for example, the preemptive statute at issue authorized the President to impose sanctions on the Burmese regime. 530 U.S. at 366. The statute disavowed creation of any individual rights, and it did not provide a cause of action against anyone, much less against a state in the unexpected event that one might adopt its own conflict-

ing Burma sanctions policy. See Omnibus Consolidated Appropriations Act, Pub. L. No. 104-208, § 570, 110 Stat. 3009 (1996); Exec. Order No. 13,047, § 7, 62 Fed. Reg. 28,301 (May 20, 1997) ("Nothing contained in this order shall create any right or benefit, substantive or procedural, enforceable by any party against the United States * * * or any other person."); 31 C.F.R. pt. 537 (2003). This Court granted prospective injunctive relief notwithstanding the absence of a statutory right or cause of action. Congress undoubtedly intends that state government officers may not systematically violate federal statutes, even ones that do not directly regulate states. By recognizing an implied cause of action under the Supremacy Clause in *Crosby*, the Court gave effect to that congressional intent, and vindicated the structural federalism that is fundamental to constitutional design. See *Bond v. United States*, 131 S. Ct. 2355, 2364 (2011) ("An individual has a direct interest in objecting to laws that upset the constitutional balance between the National Government and the States when enforcement of those laws causes injury that is concrete, particular, and redressable.").

Significantly, pursuant to the Supremacy Clause, federal legislation may constrain a state in ways that private actors are not. In *Crosby*, for example, the federal Burma sanctions act did not preclude a private individual or corporation from engaging in a secondary boycott of companies that did business with Burma. But, under the Supremacy Clause, *a state* was foreclosed from adopting such a sanctions policy because it undermined the President's capacity for diplomacy, which was central to the federal sanctions legislation. Conversely, a federal statute that regulates automobile manufacturers may have no direct application to states

at all, but nonetheless constrains a state from adopting legislation that conflicts with the federal standard. Thus, asking whether the statute provides a statutory cause of action to enforce its mandate tells one little, if anything, about whether Congress intended that a cause of action be available to set aside a state law that conflicts with the federal policy. In short, a statutory cause of action to enforce the statute's requirements through affirmative relief is distinct from a cause of action under the Supremacy Clause to set aside an inconsistent state law. The availability, or absence, of the former type of action is inapposite to the availability of the latter.

B. A Supremacy Clause Cause Of Action Is Not Limited To Parties Who Are "Regulated" By The Invalid State Statute, But If It Were, Medicaid Providers Would Qualify

Apparently recognizing that they cannot explain this Court's Supremacy Clause precedent by reference to statutes that provided statutory rights or causes of action, petitioners urge that the remaining cases merely represent instances in which a regulated party that might otherwise have raised preemption as a defense to an enforcement action was permitted to bring an anticipatory claim for declaratory relief. Pet. Br. 43. That explanation also fails to account for the full breadth of the Court's preemption precedent. But, to the extent petitioners' definition of "regulated" parties is broad enough to encompass the remaining precedent, Medicaid providers would easily so qualify.

Notably, petitioners appear to recognize that their framework cannot explain the Court's decision in *Crosby*, and so petitioners ignore the case. The Solicitor

General readily acknowledges that *Crosby* does not "readily" fit petitioners' artificially constructed category. U.S. Br. 23 n.8. The government contends, however, that *Crosby* is sufficiently analogous to the anticipatory assertion of a defense against enforcement because "the state law was an affirmative (and independent) exercise of the State's authority to impose and enforce what were essentially state regulatory standards." *Ibid.* But that is not accurate. In *Crosby*, Massachusetts had adopted a law prohibiting state contracting officers from purchasing goods from companies that did business with Burma. 530 U.S. at 367-370. There were no "enforcement" proceedings that could be brought against such companies; they were simply ineligible for government contracts.[8]

Even assuming that it is necessary to be a "regulated" entity in order to maintain a Supremacy Clause challenge, Medicaid providers are easily as "regulated" by a State's Medicaid payment rates as were the business plaintiffs in *Crosby*. Medicaid providers are paid directly by Medicaid for the services they provide to eligible beneficiaries, and, significantly, these payments must be accepted as payments in full. See Cal. Welf. & Inst. Code § 14019.4(a) & (c); see also 42 U.S.C. 1320a-7b(d); 42 C.F.R. 447.15; *Rehab. Ass'n of Va.* v. *Kozlowski*, 42 F.3d 1444, 1447 (4th Cir. 1994), cert. denied 516 U.S. 811 (1995). Moreover, although providers, like

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[8] Ironically, the Solicitor General's position here would defeat its ongoing challenge to Arizona's immigration law, SB 1070. *United States* v. *Arizona*, 641 F.3d 339 (9th Cir. 2011). The federal government is not subject to enforcement under the law, and, moreover, portions of Arizona's immigration statute directly regulate only state officials. See, *e.g.*, A.R.S. § 11-1051.

states, "opt in" to Medicaid, non-participation is virtually impossible as a matter of practical necessity. Providers who choose not to participate in Medicaid face significant potential consequences. For instance, the Emergency Medical Treatment and Active Labor Act ("EMTALA"), 42 U.S.C. 1395dd *et seq.*, requires hospitals with emergency departments to treat Medicaid beneficiaries who present themselves to those emergency departments. Violations of EMTALA carry significant civil penalties; see also Bradley J. Sayles, *Preemption or Bust: A Review of Recent Trends in Medicaid Preemption Actions*, 27 J. Contemp. Health L. & Pol'y 120, 123-124 (2011). Medicaid providers are, thus, at least as directly affected by a state's across-the-board cut in payment rates as were the businesses in *Crosby*, which simply wanted to be able to bid for more work from Massachusetts. To the extent that Supremacy Clause challenges are limited to "regulated" entities, respondents certainly qualify under the criteria applied in *Crosby*.

The "regulated party" test, as construed by the Solicitor General, really amounts to a proxy for the kind of direct injury that would give a party standing. See *Bond*, 131 S. Ct. at 2363-2365 (holding that individuals with concrete injury have "standing to object to a violation of a constitutional principle that allocates power within government"). Here, there is no doubt that respondents and the patients they treat would be directly injured if California were permitted to implement its illegal rate cuts, and their Supremacy Clause challenge is therefore proper.

C. There Is No Basis For According Spending Clause Legislation Less Effect Under The Supremacy Clause

Nothing in the text of the Constitution limits the preemptive effect of a law depending upon the constitutional power Congress was exercising in adopting the statute. The preemptive effect under the Supremacy Clause of statutes enacted under the Spending Clause is the same as for laws enacted under any other constitutional power. Like all statutes, laws enacted under the Spending Clause are "supreme" over inconsistent state law.

Thus, this Court has repeatedly recognized the preemptive power of Spending Clause legislation, including Medicaid in particular, over conflicting state statutes. See, *e.g.*, *Dalton* v. *Little Rock Family Planning Servs.*, 516 U.S. 474, 476-478 (1996) (per curiam) (leaving in place district court injunction enjoining application of state law prohibiting expenditure of state funds for abortions in the case of incest or rape to the extent it "imposed obligations inconsistent with" the Hyde Amendment to the Medicaid Act, a spending bill); *Blum* v. *Bacon*, 457 U.S. 132, 145-146 (1982) (state program discriminating against AFDC beneficiaries preempted by federal regulation); *Carleson* v. *Remillard*, 406 U.S. 598, 604 (1972) (state rule denying assistance to children of military members preempted by AFDC); *cf. Pennsylvania Prot. & Advocacy, Inc.* v. *Houstoun*, 228 F.3d 423, 428 (3d Cir. 2000) (Alito, J.). Similarly, in *Townsend* v. *Swank*, 404 U.S. 282, 285 (1971), this Court held that an Illinois statute was "invalid under the Supremacy Clause" because it conflicted with the Aid to Families with Dependent Children program, a provision of the Social Security Act that

was adopted as Spending Clause legislation. See also *Ark. Dep't of Health & Human Servs.*, 547 U.S. at 268.

D. Congress Did Not Adopt An Exclusive Administrative System To Enforce Section 30(A) That Would Preclude Challenges Under The Supremacy Clause

Petitioners contend that permitting a cause of action under the Supremacy Clause is incompatible with "Congress's decision to centralize enforcement authority in HHS." Pet. Br. 26. There is nothing in Medicaid's administrative scheme, however, to suggest that Congress viewed private suits to set aside preempted state statutes as inconsistent with that scheme. Indeed, the Solicitor General disavows any suggestion that "Congress has displayed an intent" to preclude Supremacy Clause challenges. *See* U.S. Br. 32 n.12 (internal quotation omitted). The most the Solicitor General can say is that Section 30(A) would not be "a 'dead letter'" if Supremacy Clause challenges were not permitted. *Ibid.* But that is insufficient to support petitioners' argument for administrative exclusivity.

Petitioners cite this Court's decision in *Astra USA, Inc.* v. *Santa Clara County*, 131 S. Ct. 1342 (2011), in support of their argument, but that case is readily distinguishable. See Br. of Intervenor Resp. in No. 09-958 and California Pharmacists Resp. in No. 09-1158, at 41-42. In particular, the 340B program stands in stark contrast to Section 30(A). In *Astra*, participating pharmaceutical manufacturers each signed a *standard-form* Pharmaceutical Pricing Agreement ("PPA") with HHS. 42 U.S.C. 256b(a). The PPA specifies the maximum price at which manufacturers may sell their drugs to eligible providers, with this price being determined

using a uniform statutory formula. The Medicaid Act, by contrast, is almost unique in its lack of uniformity across the Nation. State Medicaid programs differ significantly from one another. The Medicaid Act permits states to develop unique benefit structures, delivery systems, and payment methodologies. Such a structure does not allow for enforcement under a single nationwide standard.

As previously discussed, *see supra*, 16-21, the administrative system for monitoring compliance with Section 30(A) is particularly lacking. The agency relies on the submission of state plan amendments as the only opportunity to assess rate cuts, and, even then, the agency is entirely dependent on the information submitted by the state. Even when the state ignores the administrative process, it is free to move ahead with its rate cuts with seeming impunity. That is hardly the type of "centraliz[ed] enforcement authority" that would preclude other available means of preventing states from enforcing laws that were contrary to Medicaid's mandates.

CONCLUSION

The Court should affirm the holding of the court of appeals.

Respectfully submitted.

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APPENDIX
DESCRIPTION OF AMICI CURIAE

The American Health Care Association ("AHCA") is the national representative of nearly 11,000 non-profit and proprietary facilities dedicated to improving the delivery of professional and compassionate care to more than 1.5 million citizens who live in skilled nursing facilities, subacute centers and homes for persons with developmental disabilities. In addition, AHCA's National Center for Assisted Living is a federation of state affiliates representing more than 2,700 non-profit and for-profit assisted living and residential care communities nationwide.

The American Hospital Association ("AHA") represents nearly 5,000 hospitals, health care systems, and other health care organizations, as well as 42,000 individual members. AHA members are committed to improving the health of the communities they serve including the more than 68 million children, poor, disabled and elderly individuals who rely on the Medicaid program for their health care.

The Association of American Medical Colleges ("AAMC") is a not-for-profit association representing all 135 accredited U.S. medical schools and nearly 300 major teaching hospitals and health systems. The AAMC represents 128,000 faculty members, 75,000 medical students, and 110,000 resident physicians. While the country's 273 major teaching hospitals represent just 6 percent of all hospitals and 23 percent of all hospital admissions, they account for one-quarter of all Medicaid discharges and over 40 percent of all hospital charity care. Additionally, Medicaid patients account for nearly one-sixth (17 percent) of healthcare

services provided by physician faculty practice groups. This rate is over 50 percent higher than the average for community-based multi-specialty groups.

The Catholic Health Association of the United States ("CHA") is the national leadership organization for the Catholic health ministry. CHA's more than 2,000 members operate in all 50 states and offer a full continuum of care, from primary care to assisted living. CHA works to advance the ministry's commitment to a just, compassionate health care system that protects life.

The Federation of American Hospitals ("FAH") is the national representative of investor-owned or managed community hospitals and health systems. FAH has nearly 1,000 member hospitals in 46 states and the District of Columbia. These members include rural and urban teaching and non-teaching hospitals and provide a wide range of acute, post-acute, and ambulatory services. Our hospitals have long been a critical part of the safety net serving vulnerable patients in urban and rural communities.

The National Association of Children's Hospitals ("N.A.C.H.") supports its 221 hospital members in addressing public policy issues. N.A.C.H.'s mission is to promote the health and well-being of children and their families through support of children's hospitals and health systems. Medicaid is the single largest insurer of children and the single largest payer for children's hospitals. On average, 50 percent of the patients at children's hospitals are enrolled in Medicaid.

The National Association of Community Health Centers is the national membership organization for federally-supported and federally-qualified health cen-

ters throughout the country. There are, at present, more than 1,200 health center entities nationwide, which serve as the health care homes to twenty (20) million persons at more than 8,000 sites. Approximately 40 percent of patients served by health centers are uninsured and approximately 35 percent (6.9 million) are Medicaid recipients.

The National Association of Public Hospitals and Health Systems ("NAPH") is comprised of some 140 of the nation's largest metropolitan safety net hospitals and health systems, committed to providing health care to all without regard to ability to pay. Over 35 percent of NAPH member net revenues are attributable to Medicaid.

The National Council for Community Behavioral Healthcare represents 1,950 behavioral healthcare organizations that provide treatment and rehabilitation for mental illnesses and addictions disorders to nearly six million adults, children and families in communities across the country.

Safety Net Hospitals for Pharmaceutical Access ("SNHPA") represents over 700 public and private non-profit hospitals and health systems throughout the U.S. that participate in the Public Health Service 340B drug discount program. SNHPA monitors, educates, and serves as an advocate on federal legislative and regulatory issues related to drug pricing and other pharmacy matters affecting safety-net providers.

RECORD AND BRIEFS

Nos. 09-958, 09-1158, and 10-283

Supreme Court, U.S.
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In The
Supreme Court of the United States

TOBY DOUGLAS, Director of the Department of Health Care Services, State of California, *Petitioner,*

v.

INDEPENDENT LIVING CENTER OF SOUTHERN CALIFORNIA, INC., A Nonprofit Corporation, et al.

TOBY DOUGLAS, Director of the Department of Health Care Services, State of California, *Petitioner,*

v.

CALIFORNIA PHARMACISTS ASSOCIATION, et al.

TOBY DOUGLAS, Director of the Department of Health Care Services, State of California, *Petitioner,*

v.

SANTA ROSA MEMORIAL HOSPITAL, et al.

On Writs Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

CONSOLIDATED BRIEF OF THE AMERICAN MEDICAL ASSOCIATION, AMERICAN DENTAL ASSOCIATION, AMERICAN ACADEMY OF PEDIATRICS, AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN ACADEMY OF FAMILY PHYSICIANS AND THE AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS

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INTEREST OF *AMICI CURIAE*

Amici are among the largest and most prominent medical and dental professional associations in the United States.[1] Collectively, the members of these professional associations provide medical and dental services to literally millions of patients covered by the Medicaid program. *Amici* are uniformly committed to promoting the betterment of public health and improved access to health and dental care for Medicaid recipients. They are profoundly interested in this case because its outcome will affect the ability of all Medicaid recipients to assure that they have access to medically necessary services as mandated by the Medicaid Act. States' failure to comply with the Medicaid Act's "equal access" provision has a well-documented and negative impact on patient care, often creating unnecessary risks and poor health outcomes. Restricting the availability of a remedy through the courts would leave the Congressional mandate of "equal access" an empty promise.

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[1] Pursuant to Rule 37, letters of written consent from the parties have been filed with the Clerk of the Court. In accordance with Rule 37.6, *Amici* state that no counsel for either party has authored this brief in whole or in part. Funding for this brief, in part, has come from the Litigation Center of the AMA and the State Medical Societies, a coalition among the AMA and the State Medical Societies, whose purpose is to represent the organized medical profession in the courts. With the exception of the funding provided by the Litigation Center, no person or entity, other than *Amici*, has made any monetary contribution to the preparation or submission of this brief.

The American Medical Association ("AMA") is the largest professional association of physicians, residents and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups, seated in the AMA's House of Delegates, substantially all physicians, residents and medical students in the United States are represented in the AMA's policy making process. The objectives of the AMA are to promote the science and art of medicine and the betterment of public health.

American Dental Association ("ADA") is the world's largest professional association of dentists. The ADA is committed to the public's oral health, and to the ethics, science and professional advancement of dentistry. On behalf of its more than 155,000 members, the ADA occupies a prominent role in leading the profession through initiatives in advocacy, education, research and the development of standards that are essential for the safe, appropriate and effective delivery of oral healthcare. The Association is vitally concerned with access to care issues and serves as a principal advocate on issues affecting oral health.

The American Academy of Pediatrics ("AAP") is an Illinois not-for-profit corporation representing 60,000 primary care pediatricians, pediatric medical subspecialists and pediatric surgical specialists. Founded in 1930, AAP has been a powerful voice for children's health through education, research, advocacy, and the provision of expert advice. Its mission is to attain optimal physical, mental, and social health and well-being for all infants, children, adolescents,

and young adults. AAP is the largest professional association of pediatricians in the world.

The American Congress of Obstetricians and Gynecologists ("ACOG") is an Illinois not-for-profit corporation representing more than 50,000 obstetricians and gynecologists and residents in obstetrics and gynecology. ACOG is dedicated to the advancement of women's healthcare and to establishing and maintaining the highest possible standards of practice. ACOG also promotes policy positions on issues affecting the specialty of obstetrics and gynecology and supports quality health care for every woman throughout her life.

The American Academy of Family Physicians ("AAFP"), headquartered in Leawood, Kansas, is the national association of family doctors. Founded in 1947 as a not-for-profit corporation, its members are physicians and medical students from all 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, and the Uniformed Services of the United States. As part of its mission, the AAFP seeks to improve the health of patients, families, and communities by serving the needs of members and their patients with professionalism and dignity and by advocating for public health.

The American College of Emergency Physicians ("ACEP") is a nonprofit, voluntary professional and educational society of over 29,000 emergency physicians practicing in the United States and other countries. Founded in 1968, ACEP is the nation's oldest

and largest association of emergency physicians. ACEP fosters the highest quality of emergency medical care through the education of emergency physicians, other health care professionals, and the public; the promotion of research; the development and promotion of public health and safety initiatives; and the provision of leadership in the development of health care policy.

Many of *Amici*'s members care for Medicaid patients. Low Medicaid reimbursement rates impose an unfair burden on those members who accept these patients, and additional members of *Amici* would care for Medicaid patients if the reimbursement rates were not prohibitively low.

SUMMARY OF ARGUMENT

The "equal access" provision of the Medicaid Act, 42 U.S.C. § 1396a(a)(30)(A), mandates that states accepting federal Medicaid funds set provider reimbursement rates using "such methods and procedures" as necessary to assure, among other things, that payments are "sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." As a practical reality, however, the promise of "equal access" has been largely illusory for many of America's most vulnerable citizens. Federal courts, scientific researchers and governmental

bodies have consistently found a chasm between Medicaid and private insurance in the availability of needed health care services. Twenty years after the statutory enactment of the equal access mandate, discrepancies in access to care pervade. Members of the *Amici* see these discrepancies every day in their own practices. Whether it be a futile attempt to find a Medicaid-participating pediatric neurologist or dentist for a young patient or treating a Medicaid beneficiary in the emergency room who cannot find a primary care physician, there are constant reminders of the access crisis in our public health system.

There is a well-established and predictable correlation between Medicaid provider payments and physicians' willingness to treat Medicaid recipients. Indeed, the equal access provision was itself enacted with the common sense recognition that "without adequate payment levels, it is simply unrealistic to expect physicians to participate in the [Medicaid] program." H.R. Rep. No. 101-247, at 390 (1989). The United States Government Accountability Office ("GAO") recently reported that for physicians who choose not to participate in Medicaid and the Children's Health Insurance Program ("CHIP"), *95%* are influenced by low provider reimbursement rates. *See* "Medicaid and CHIP: Most Physicians Serve Covered Children but Have Difficulty Referring Them for Specialty Care," GAO-11-624, at 18 (hereinafter

referred to as "2011 GAO Report").[2] Nevertheless, state officials have engaged in widespread violations of the federal equal access mandate, wholly failing to consider the effect of rates on access to care and services.

Federal administrative enforcement provides no viable solution to the access crisis because Congress delegated only limited, and draconian, enforcement powers. The primary administrative enforcement tool – a revocation of funding – is severe and would cause further harm. Thus, without judicial remedies, this crisis will remain and likely worsen. If the courthouse doors are closed, the very people the Medicaid Act was intended to serve will have no reasonable hope that "equal access" will have any true meaning in their lives.

Such a result would also violate fundamental rule of law principles. "'This is a government of laws and not of men,' 'No man is above the law,' are . . . maxims showing the spirit in which Legislatures, executives and courts are expected to make, execute and apply laws." *Truax v. Corrigan*, 257 U.S. 312, 332 (1921). Yet, without judicial remedies, state officials' violations of federal law will go unchecked in direct contravention of these principles, all while beneficiaries suffer.

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[2] *Available at*: http://www.gao.gov/new.items/d11624.pdf.

It is, after all, the welfare of these beneficiaries that is of primary concern to the *Amici*. The real human suffering occasioned by noncompliance can be lost in a sterile discussion of the law. This is particularly true with the Medicaid Act, as it indisputably impacts the health of millions of low income Americans. This human importance of the Medicaid Act was aptly summarized by the United States District Court for the District of Columbia in *Salazar v. District of Columbia*, 954 F. Supp. 278, 281 (D.D.C. 1996):

> This case is about people – children . . . who are sick, poor, and vulnerable – for whom life, in the memorable words of poet Langston Hughes, "ain't been no crystal stair." It is written in the dry and bloodless language of "the law" – statistics, acronyms of agencies and bureaucratic entities, Supreme Court case names and quotes, official governmental reports, periodicity tables, etc. But let there be no forgetting the real people to whom this dry and bloodless language gives voice: anxious, working parents who are too poor to obtain medications or heart catheter procedures or lead poisoning screens for their children . . . Behind every "fact" found herein is a human face and the reality of being poor in the richest nation on earth.

If the equal access mandate is ever to fulfill its promise, these "real people" must have a voice in the courts.

In sum, if states are permitted to simply disregard the equal access provision with impunity, not only will violations of federal law go unchecked, but

millions of people, including millions of children, will continue to be placed at unnecessary risk of harm or even death. Judicial enforcement of the equal access provision is mandated as a matter of law and vital as a matter of fact. The *Amici* strongly urge this Court rule in favor of Respondents.

ARGUMENT

MEDICAID BENEFICIARIES MUST HAVE ACCESS TO THE COURTS TO ENFORCE THE EQUAL ACCESS PROVISION IN ORDER TO UPHOLD THE RULE OF LAW AND BECAUSE JUDICIAL ENFORCEMENT IS THE *ONLY* VIABLE MEANS TO REMEDY STATES' NONCOMPLIANCE WITH THE MEDICAID ACT

A. The Medicaid Act, Children's Health Care and the "Equal Access" Mandate

From very early on, it was evident that the Medicaid program was intended to improve health care for America's poor, with a particular emphasis on children's health. Title XIX of the Social Security Act, commonly known as the Medicaid Act, was first enacted in 1965. *See* Pub. L. No. 89-97, 79 Stat. 343 (1965) (codified as amendment at 42 U.S.C. § 1396). The Medicaid program, as established by the Medicaid Act, is a cooperative federal-state program for furnishing and financing health care and services to certain low income families and individuals. States

that choose to participate in Medicaid are required to provide coverage to seven designated classes of "categorically needy" persons, with the option to extend coverage to other designated individuals, known as "medically needy." *See* 42 U.S.C. §§ 1396a(a)(10)(A)(i), (a)(10)(C), (a)(17) and § 1396d.

In 1967, Congress amended the Medicaid Act to impose the explicit and mandatory children's health care program – which has come to be known as Early and Periodic Screening, Diagnosis and Treatment, or "EPSDT" – upon every state choosing to accept federal Title XIX funds. *See* Pub. L. No. 90-248, 81 Stat. 821 (1967). As this Court has previously noted, "EPSDT programs provide health care services to children to reduce lifelong vulnerability to illness or disease." *Frew ex rel. Frew v. Hawkins*, 540 U.S. 431, 433-34 (2004).

The children's health amendments were enacted amidst growing concerns about the lack of available pediatric health care and correlative effects on education. In his February 8, 1967 "Special Message to Congress," President Johnson stated:

> Recent studies confirm what we have long suspected. In education, in health, in all of human development, the early years are the critical years. Ignorance, ill health, personality disorder – these are disabilities often contracted in childhood: afflictions which linger to cripple the man and damage the next generation. Our nation must rid itself of this bitter inheritance. Our goal must be clear – to

> give every child the chance to fulfill his promise.
>
> * * *
>
> I am requesting increased funds for the "Medicaid" program, including . . . legislation to expand the timely examination and treatment of . . . poor children. . . .
>
> * * *
>
> We look toward the day when every child, no matter what his color or his family's means, gets the medical care he needs, starts school on an equal footing with his classmates, seeks as much education as he can absorb – in short, goes as far as his talents will take him.

Available at: http://www.presidency.ucsb.edu/ws/index.php?pid=28438&st=Medicaid&st1=Johnson. At this early stage in the life of Medicaid, the President and Congress placed special emphasis on low income children's health care, recognizing the potential for Medicaid to influence growth and development and to act as a catalyst for equality in health care and education. Unfortunately, however, after passage of the children's health amendments, many of the problems identified by President Johnson in 1967 persisted.

In 1989, Congress statutorily specified the required elements of EPSDT in 42 U.S.C. § 1396d(r). *See* Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, 1989 U.S.C.C.A.N. (103 Stat. 2106) 2262-63. In defining EPSDT services, Congress required

states to include four types of specific services: preventive screening, vision, dental, and hearing examinations. In addition to these specific preventive services, the statute mandates the provision of:

> [s]uch other necessary health care, diagnostic services, treatment, and *other measures described in subsection (a)* of this section to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, *whether or not such services are covered under the State plan.*

42 U.S.C. § 1396d(r)(5)(emphasis added). In other words, the EPSDT mandate broadly requires that states furnish covered children (individuals under the age of 21) with *all medically necessary health care services. See, e.g., S.D. ex rel. Dickson v. Hood,* 391 F.3d 581, 590 (5th Cir. 2004); *Collins v. Hamilton,* 349 F.3d 371, 376 n. 8 (7th Cir. 2003).

As noted in the House Report generated in connection with the 1989 amendments, "[t]he EPSDT benefit is, in effect, the nation's largest preventative health care program for children." H.R. Rep. No. 101-247, 398-401, reprinted in 1989 U.S.C.C.A.N. 1906, 2124. Congress further left no doubt of its intent that children covered by Medicaid actually receive the services mandated by the EPSDT amendments. *Id.* at 2124-25. To this day, the Medicaid Act's EPSDT program is the primary source of necessary and vital health care services for millions of America's children.

Recognizing that the "eligibility expansions . . . for poor pregnant women . . . and poor children will not have their intended effect if physicians are not willing to treat Medicaid patients,"[3] Congress also enacted, as part of the 1989 amendments, the "equal access" provision. *See* 42 U.S.C. § 1396a(a)(30)(A). Consistent with the overall Congressional goal of improving children's health, the House Report indicates that the equal access provision was enacted, in large part, to address concerns over "inadequate" Medicaid participation of "physicians generally, and obstetricians and pediatricians in particular. . . ." H.R. Rep. No. 101-247 at 389 (1989). The House Committee found that Medicaid payment rates were an "important factor" in a physician's decision whether to accept Medicaid patients and was persuaded by hearing testimony that Medicaid payment rates had not kept pace with average community rates. *Id.* at 389-90. The House Report expresses a clear and common sense statement of the connection between provider payment rates and recipient access to health care services: "the Committee believes that, *without adequate payment levels, it is simply unrealistic to expect physicians to participate in the program.*" *Id.* at 390 (emphasis added).

In 1997, Congress created CHIP, Title XXI, to give states the option of covering additional uninsured children with family incomes up to 200% of the

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[3] H.R. Rep. No. 101-247 at 390 (1989).

poverty level. *See* 42 U.S.C. §§ 1397aa; 1397jj(c)(4). Under CHIP, states are given flexibility to simply expand traditional Medicaid coverage. *See* 42 U.S.C. §§ 1397aa(a), 1397ee(c)(2). Funding for CHIP was renewed as part of the CHIP Reauthorization Act of 2009. *See* P.L. 111-3, 123 Stat. 8 (2009).

Judicial enforcement of substantive Medicaid Act provisions was contemplated by Congress. Eight years prior to the 1989 amendments, the House Committee Report on amendments to the Medicaid Act provided: "in instances where the States or the Secretary fail to observe these statutory requirements, the *courts would be expected to take appropriate remedial action.*" H.R. Rep. No. 97-158 at 301 (1981) (emphasis added). As the Third Circuit later observed, "[t]his statement certainly suggests that the Committee anticipated *that some class of plaintiffs would be able to sue to enforce Section 30(A). . . .*" *Pennsylvania Pharmacists Ass'n v. Houstoun*, 283 F.3d 531, 541 (3rd Cir. 2002) (en banc) (Alito) (emphasis added).[4] In the same vein, the Health Care

[4] The present case arises from circumstances in which the Supremacy Clause has been invoked to secure state compliance with the Medicaid Act's equal access mandate. The enforceability of the equal access mandate under 42 U.S.C. § 1983 is not at issue in this case and need not be decided by this Court. In any event, these *Amici* maintain that such a private right of action does exist pursuant to § 1983, and they are joined in that proposition by the district court holding in *Florida Pediatric Society v. Dudek*, 05-23037-CIV (S.D.Fla., Sept. 30, 2009) (Dkt. #672) (relying on *Wilder v. Virginia Hosp. Ass'n*, 496 U.S. 498 (1990)).

Financing Administration ("HCFA"), now the Centers for Medicare & Medicaid Services ("CMS"), later warned state Medicaid directors that "[i]nadequate Medicaid non-institutional provider rate structures may expose a state to serious litigation risk [with respect to equal access claims]." Letter from HCFA Director to State Medicaid Directors, SMDL #01-010, at 3 (Jan. 18, 2001), *Available at*: https://www.cms.gov/smdl/downloads/ smd011801a.pdf.[5]

B. The Access Gap Between Congressional Promise and Actual Implementation

There are approximately 61 million Medicaid enrollees in the United States, of whom 33 million are under age 21 and 31 million are under the age of 19. *See* Medicaid State Reports, FY 2008, published by CMS for Federal Fiscal Year 2008.[6] This is the equivalent of 37.6% of the total population of persons under age 21 and 38.9% of the total population under age 19. Despite the undeniable prominence and importance of Medicaid as a health insurer in America, there remain vast disparities between Medicaid and private insurance[7] in the availability of medically

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[5] In the same letter, the HCFA Director indicates that as of January 2001, there had been 22 dental access cases in 18 States, and of those, 16 had been decided or settled favorably for the plaintiffs. *See* Letter from HCFA Director at 3.

[6] *Available at*: http://www.aap.org/research/pdf08/US.pdf.

[7] Courts have found that "the test for evaluating access is to compare the access of [beneficiaries] living in a specific

(Continued on following page)

necessary health care. Testimony from physicians, dentists and beneficiaries alike in litigation involving noncompliance with the Medicaid Act's equal access and EPSDT provisions paint the picture of a truly inferior health care system for Medicaid recipients. It is a system under which medically inappropriate delays in treatment are commonplace, putting patients, most especially children, at unnecessary risk.

Large percentages of recipients receive no mandatory preventive health screening examinations. Primary care providers struggle to find specialists willing to accept Medicaid enrolled patients. Medicaid enrolled children may wait upwards of one year to see a pediatric neurologist, or they may have to travel out-of-state to find an available specialist. Many Medicaid recipients have simply given up on finding *any* dentist who accepts Medicaid. There are even documented instances of young Medicaid recipients dying while awaiting necessary treatment. Regrettably, constrained, nonexistent access for Medicaid

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geographic area [to] the access of [other] individuals in the same area [with] private or public insurance coverage." *Clark v. Kizer*, 758 F. Supp. 572, 576 (E.D.Cal. 1990), *aff'd in relevant part sub nom.*, *Clark v. Coye*, 967 F.2d 585 (9th Cir. 1992) (citing H.R. Rep. No. 101-247, at 390-91). *See also Ark. Med. Soc'y v. Reynolds*, 6 F.3d 519, 527 (8th Cir. 1993) ("To suggest that Congress appropriated vast sums of money and enacted a huge bureaucratic structure to ensure that recipients of the federal Medicaid program have equivalent access to medical services as their uninsured neighbors (i.e., close to none) is ridiculous.")

recipients is no rarity. By contrast, the insured population does not usually face such access problems.

As one court summarized after a full trial on the merits of an equal access claim:

> Most doctors in Cook County [, Illinois] will either not see children on Medicaid or significantly limit the number of children on Medicaid that they will accept as patients.
>
> * * *
>
> A substantial number of children on Medicaid have had adverse health outcomes because they have not been able to see a pediatrician regularly due to their difficulty in finding a pediatrician. In addition, waiting times in specialty treatment clinics for the plaintiffs are long and oftentimes put patients in danger.
>
> * * *
>
> Medicaid recipients may have to travel great distances to find a dentist or pediatric provider willing to accept Medicaid, if they can find one at all. Children on Medicaid frequently seek care at emergency rooms because they cannot find a pediatrician willing to accept Medicaid.

Memisovski v. Maram, 2004 WL 1878332, *17-18 (N.D.Ill., Aug. 23, 2004).

Several other courts in geographically diverse locations have made similar findings over the years. *See, e.g., Oklahoma Chapter of the American Academy*

of Pediatrics ("OKAAP") v. Fogarty, 366 F. Supp. 2d 1050, 1107 (N.D.Okla. 2005), *rev'd, OKAAP v. Fogarty,* 472 F.3d 1208, 1215 (10th Cir. 2007) ("[T]he lack of physician participation in Medicaid forces class members either to wait for unreasonable periods of time to receive needed care or to travel long distances to find Medicaid participating providers, putting these children at risk of harm or even death.");[8] *Rosie D. v. Romney,* 410 F. Supp. 2d 18, 23 (D.Mass. 2006) ("At present, thousands of needy . . . children [diagnosed with serious emotional disturbances] lack comprehensive assessments; treatment occurs haphazardly, with no single person or entity providing oversight and ensuring consistency"); *Health Care for All v. Romney,* 2005 WL 1660677, *10 (D.Mass., July 14, 2005) ("Plaintiffs' evidence shows that [Medicaid] enrollees encountered extraordinary difficulty in obtaining timely dental services"); *Salazar v. District of Columbia,* 954 F. Supp. 278, 304 (D.D.C. 1996)

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[8] The Tenth Circuit Court of Appeals reversed the *OKAAP* district court's determination that the defendants violated the equal access mandate on purely legal grounds, determining that the plaintiffs had no right to enforce the equal access provision pursuant to 42 U.S.C. § 1983. *OKAAP,* 472 F.3d at 1215. The Tenth Circuit did *not* challenge the district court's underlying findings of fact. To the extent that the Tenth Circuit addressed the findings at all, it conceded that the district court "perhaps correctly" concluded that the "low rates of reimbursement reduce the number of providers available to Medicaid beneficiaries, and in turn increase the time Medicaid beneficiaries must wait to receive medical services from available providers. . . ." *Id.* at 1214; *see also id.* at 1209 (noting "system-wide delays in treatment of Medicaid beneficiaries").

("Plaintiffs have produced significant evidence to show that Defendants have failed to deliver EPSDT services to eligible children"); *Clark v. Kizer,* 758 F. Supp. 572, 576 (E.D.Cal. 1990), *aff'd in relevant part sub nom., Clark v. Coye,* 967 F.2d 585 (9th Cir. 1992) ("The undisputed facts in this case establish that less than 40% of the licensed dentists in the state treat any Denti-Cal recipients."). All of these findings, of course, were made prior to the additional strains on the Medicaid system that have arisen from the current economic downturn.

Published scientific studies also consistently confirm that access to health care and dental services is generally poor for Medicaid recipients when compared to access enjoyed by the privately-insured population. *See, e.g.,* J. Bisgaier et al., *Disparities in Child Access to Emergency Care for Acute Oral Injury,* 127 Pediatrics e1428 (2011); J. Bisgaier & K. Rhodes, *Auditing Access to Specialty Care for Children with Public Insurance,* 364 New Eng. J. Med. 2324 (2011); S. Decker, *Medicaid Payment Levels to Dentists and Access to Dental Care Among Children and Adolescents,* 306 JAMA 187 (2011); C. Iobst et al., *Access to Care for Children with Fractures,* 30 J. Pediatric Orthopaedics April/May 2010 at 244; A. Skinner & M. Mayer, *Effects of Insurance Status on Children's Access to Specialty Care: A Systemic Review of the Literature,* 7 BMC Health Serv. Res. 194 (2007); D. Skaggs et al., *Access to Orthopedic Care for Children with Medicaid Versus Private Insurance: Results of a National Survey,* 26 J. Pediatric Orthopaedics

May/June 2006, at 400; Medical Access Study Group, *Access of Medicaid Recipients to Outpatient Care,* 330 New Eng. J. Med. 1426-30 (1994). Similar studies have been presented by expert witnesses, admitted into evidence, and relied upon by courts in finding violations of the "equal access" provision. For instance, the United States District Court for the Northern District of Oklahoma relied upon survey results showing that only 34% of Oklahoma's pediatricians accepted all new Medicaid patients, while 69% accepted all new privately insured patients. *OKAAP*, 366 F. Supp. 2d at 1063; *see also Memisovski,* 2004 WL 1878332 at *13.

Recent data demonstrate that Medicaid's access conundrum is widespread and continuing. The 2011 GAO Report documents the results of a nationwide study of children's access to care under Medicaid and CHIP, including information on physicians' willingness to serve children covered under these public health care programs. *See* 2011 GAO Report at 1.[9] Some of the findings are alarming. For instance, GAO found that about 80% of physicians are accepting all

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[9] Medicaid and CHIP are closely related public health programs. As GAO states, both Medicaid and CHIP are "joint federal-state health care programs for certain low income individuals" which "play a critical role in addressing the health care needs of children." 2011 GAO Report at 1. Furthermore, there are approximately five times as many children covered under Medicaid as children covered under CHIP. *Id.* at 4. Thus, data concerning access to care with respect to Medicaid and CHIP combined is indicative of access under Medicaid alone.

privately insured children as new patients, while less than 50% accept all Medicaid and CHIP children. *See* 2011 GAO Report at 10. GAO further estimates that 84% of participating physicians experience difficulty in referring Medicaid and CHIP children to specialists, compared with 26% for privately insured children. *Id.* at 20. Most dramatically, GAO specifically reports that while 34% of physicians experience "great difficulty" in referring Medicaid and CHIP children, only 1% of physicians experience such difficulty in referring privately insured children. *Id.* at 21.

In 2000, the Surgeon General reported that "Medicaid has not been able to fill the gap in providing dental care to poor children" and that "[f]ewer than one in five Medicaid children received a single dental visit in a recent year-long study." U.S. Department of Health and Human Services, *Oral Health in America: A Report of the Surgeon General – Executive Summary* (2000). By 2008, the situation had not significantly improved. GAO found that dental disease and inadequate receipt of dental care remained a serious problem for children in Medicaid, with only about one in three such children receiving *any* dental care. *See* GAO, "Medicaid: Extent of Dental Disease in Children Has Not Decreased, and Millions Are Estimated to Have Untreated Tooth Decay," GAO-08-1121, at 4 (2008). By contrast, more than one-half of privately insured children had received dental care. *Id.*

The lack of dental access can have tragic consequences. In 2007, a 12-year-old Medicaid recipient in Maryland – Deamonte Driver – died from a brain infection caused by untreated tooth decay. *See Evaluating Pediatric Dental Care under Medicaid: Hearing before the Subcommittee on Domestic Policy of the House Committee on Oversight and Government Reform* (Serial 110-8), 110th Cong., at 2-4; 13-19 (May 2, 2007).[10] Prior to his death, Deamonte's mother had unsuccessfully attempted to find a Medicaid-participating dentist to provide preventive dental care for her sons. *Id.* After Deamonte began experiencing severe headaches, he was diagnosed with a sinus infection and later rushed to the hospital. *Id.* at 13, 19. Over a period of six weeks in the hospital, Deamonte valiantly fought through two brain surgeries and a tooth extraction, only to suddenly pass away on February 25, 2007. *Id.* at 19.

Tellingly, GAO estimates that for providers who choose not to participate in Medicaid and CHIP, 95% are influenced by low provider reimbursement rates. *See* 2011 GAO Report at 18. While greatly concerning, this finding comes as little surprise to the *Amici*. For many years, provider payment rates have been linked to physicians' willingness to participate in Medicaid. Fundamentally, the Medicaid Act's equal access provision was enacted over two decades ago with the

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[10] *Available at*: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=110_house_hearings&docid=f:35772.pdf.

recognition that physicians will simply not participate in Medicaid if payments are inadequate. *See, e.g.*, H.R. Rep. No. 101-247 at 390 (1989). Since enactment, several federal courts have determined that particular states' Medicaid provider rates were insufficient to satisfy the equal access mandate. *See, e.g., Clark,* 758 F. Supp. at 577 ("The uncontroverted evidence in the record before the court . . . establishes that the present rates are not even adequate to meet overhead, let alone allowing for some marginal profit"); *Memisovski,* 2004 WL 1878332 at *45 ("Employees of the [Illinois Department of Public Aid] freely admit that rates are low and not very attractive and are set without regard to the effect such rate-setting will have on access. . . ."); *OKAAP*, 366 F. Supp. 2d at 1106 ("The record in this case demonstrates that [Oklahoma Health Care Authority] has frequently set rates below the levels which OHCA admits are adequate to assure there are enough providers to serve Medicaid enrolled children. . . .").

The continuing access crisis under Medicaid is due, in large part, to the draconian nature of the administrative enforcement mechanism. As noted *supra*, the only true enforcement tool available to the Secretary of Health and Human Services ("HHS") – a revocation of funding – would further harm the very beneficiaries the Medicaid Act was intended to protect. *See* 42 U.S.C. § 1396c.[11] By contrast, private

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[11] The current administration recently proposed a Medicaid "equal access" rule. *See* Standards for Demonstrating Access to

(Continued on following page)

lawsuits offer the possibility of increased state funding, with a real benefit to recipients in need. While such increases have actually been achieved through private legal actions, no increases have ever been achieved through HHS enforcement. Private litigation offers the only realistic prospect of an effective remedy for states' often flagrant violation of the Medicaid Act. Thus, the availability of these lawsuits is crucial, and this Court ought not diminish this necessary vehicle for achieving the Congressional purpose.

C. A Litigation Case Study of the Human Implications of States' Failures to Comply With the Medicaid Act

As foreseen by Congress and later warned of by HCFA, over the years since the 1989 amendments,

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Covered Medicaid Services, 76 Fed. Reg. 26,342-62 (2011). However, the proposed rule calls for no concrete guidelines and states the administration's intent that any final rule would not directly "require States to adjust payment rates." *Id.* at 26,344. It is also unclear, whether or how, the administration plans to enforce any such equal access rule. Indeed, neither the word "enforcement" nor "enforce" appears anywhere in the proposed rule. As several of the *Amici* recently summarized in comments on the proposed rule, "[w]ithout enforcement and comprehensiveness, CMS will have missed the opportunity to ensure that children and other populations covered under Medicaid have real access to care." Letter from AAFP, et al. to K. Sebelius (June 20, 2011), *Available at*: http://www.aafp.org/online/etc/medialib/aafp_org/documents/policy/fed/endorse-letters/medicaid062011.Par.0001.File.tmp/JointMedicaid062011.pdf.

many Medicaid beneficiaries have brought actions to enforce the equal access provision and/or EPSDT provisions of the Medicaid Act. Dealing with a broken system and with nowhere else to turn for relief, desperate beneficiaries and courageous physicians have looked to the courts to compel states' compliance. In the relatively rare instances when one of these cases has gone to a full trial on the merits, the courts' findings of fact have vividly illustrated the "real world" implications of a noncompliant Medicaid program. Courts have found large-scale failures to provide necessary services to those in need, medically inappropriate and dangerous delays in treatment and demonstrable disparities in access to needed care.

For the purposes of this Brief, the *Amici* focus on three such cases – *Memisovski v. Maram,* 2004 WL 1878332 (N.D.Ill., Aug. 23, 2004), *OKAAP v. Fogarty,* 366 F. Supp. 2d 1050 (N.D.Okla. 2005), and *Health Care for All v. Romney,* 2005 WL 1660677 (D.Mass., July 14, 2005)[12] – which detail, sometimes tragically, the very reasons it is absolutely vital that Medicaid beneficiaries (and perhaps health care providers) have access to the courts.

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[12] Unlike the underlying cases at bar, which were brought pursuant to the Supremacy Clause, *Memisovski*, *OKAAP* and *Health Care for All* were brought pursuant to 42 U.S.C. § 1983.

1. *Memisovski v. Maram*

The *Memisovski* case was a class action brought on behalf of all Medicaid-eligible children in Cook County, Illinois. Cook County is the second most populous county in the United States.[13] By the time the *Memisovski* case was tried, approximately 600,000 Cook County children were on Medicaid. *See Memisovski,* 2004 WL 1878332 at *11.

After the trial was completed, the *Memisovski* court issued its ruling in favor of the plaintiffs, bolstered by extensive findings of fact and conclusions of law. *Id.* at *11-56. The court's findings of fact read like a veritable laundry list of everything that could possibly go wrong with a state's Medicaid system. And it is apparent that much of the evidence put on by the *Memisovski* plaintiffs, which showed blatant and systemic violations of the equal access and EPSDT mandates, was not meaningfully contested by the Illinois state official defendants. *See, e.g., id.* at *45 ("defendants have no knowledge regarding the state of access for Medicaid-enrolled children in Cook County and have never tried to learn what the level of access might be. . . .")[14]

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[13] *See*: Cook County, Illinois, Geographic Information System, GIS History, http://www.cookcountygov.com/portal/server.pt/community/geographic_information_systems/315/gis_history.

[14] In fact, as lead counsel for the *Memisovski* plaintiffs represented, defendants initially took the position they were complying with the Medicaid Act because access to care was *no worse* in Illinois than in other industrial states. *See* F. Cohen, *An Unfulfilled Promise of Medicaid Act: Enforcing Medicaid*

(Continued on following page)

The *Memisovski* court's findings chronicle both statistical and anecdotal evidence of a Medicaid system in ruin. The findings exposed a system that often provided no health care at all, let alone "equal access." As noted above, the court determined that most physicians in Cook County either did not see Medicaid-enrolled children at all, or they significantly limited their Medicaid practices. *See Memisovski,* 2004 WL 1878332 at *17. This lack of available providers had a predictable negative effect on patient care. For instance, the court found that approximately 90% of Medicaid-enrolled children in Cook County had never received a vision examination, 80% had never received a hearing examination and 75% had never received a dental examination. *Id.* at *30. The court relied upon expert analysis showing that approximately one-third of the pediatric Medicaid population had never received "any preventive health care at all." *Id.* at *23.

Recipients' Right to Health Care, 17 Loy. Consumer L. Rev. 375, 390 (2005). What is more, according to counsel, defendants made this argument without conducting any analysis as to whether any of these other "industrial states" were complying with the Medicaid Act. *Id.* Given the Illinois defendants' attitude about compliance, the disintegration of the Medicaid system in Cook County should have come as no surprise. Such an attitude on the part of state Medicaid agencies is not uncommon and further exemplifies the need for enforcement in the courts. Ironically, though, there is no reason to doubt that this assertion by defense counsel was substantively correct – access to care under the Illinois Medicaid program may well have been no worse than in other industrial (as well as non-industrial) states.

"[M]any of the physicians testified that Medicaid children frequently use the emergency room as a source of primary care because they simply have nowhere else to go." *Id.* at 44. Dr. Steven Lelyveld, from the University of Chicago Hospitals' pediatric emergency room, testified that Medicaid-enrolled children with asthma, gastroenteritis, flu and diabetes "frequently presented [at the emergency room] with more aggravated or serious symptoms . . . as a result of lack of primary care." *Id.* Dr. Steven Krug, head of the emergency room at Children's Memorial Hospital in Chicago, testified that Medicaid patients in the emergency room frequently arrived with "conditions that privately-insured patients do not typically have and which reflect a lack of primary care, including untreated bone fractures or advanced asthmatic conditions." *Id.*

The *Memisovski* court also relied on the testimony of Medicaid recipients, such as Yesinia Rodriguez. Ms. Rodriguez testified concerning the extraordinary difficulty she had in locating a physician in Cook County who would accept Medicaid. When she called the Illinois hotline for a physician referral, she was given the names of approximately ten different doctors, all of whom practiced more than 30 miles away and *none* of whom accepted Medicaid. *Memisovski,* 2004 WL 1878332 at *18. When Ms. Rodriguez called the hotline back, she was given contact information for 20 more doctors. *Id.* Once again, however, *not one* of these doctors accepted Medicaid. *Id.*

The court's findings concerning Illinois' Medicaid payment rates explained why access to needed care was so inadequate for Cook County's Medicaid population. Indeed, the Illinois defendants admitted that Medicaid rates were low and unattractive and that the rates were set without any consideration of the effect on access. *Id.* at *45. The court found that Medicaid rates in Illinois were approximately 50% of Medicare rates[15] and that "[a] pediatrician practice relying solely on Medicaid beneficiaries' maximum reimbursements could not survive since Medicaid pays nearly 10% less than the median practice costs." *Id.* at *12-13. In summarizing the overwhelming evidence put on by the plaintiffs, the *Memisovski* Court stated:

> Testimony showed that Medicaid-enrolled children face conditions such as longer waiting times for care . . . , a more limited population of providers willing to provide care . . . , and multiple trips to the doctor for services which could be addressed in one visit. . . . All in all, the doctors painted a picture of Medicaid-enrolled patients being afforded a significantly lesser degree of access to care than that enjoyed by privately-insured children.

Memisovski, 2004 WL 1878332 at *43. Two generations after President Johnson publicly envisioned a

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[15] Medicare rates are an important benchmark because Medicare rates are set to allow a physician to recover overhead costs and a modest profit. *Id.* at *12.

day when, through Medicaid, "every child, no matter what his color or his family's means, gets the medical care he needs," the Medicaid system in one of most populous areas in the United States was in complete collapse.

2. *OKAAP v. Fogarty*

In *OKAAP*, as in *Memisovski*, the plaintiffs were successful in proving wholesale violations of the equal access mandate. And in the each of these cases, the district court issued detailed findings of fact evincing noncompliant and badly broken Medicaid programs. The *OKAAP* district court's findings and conclusions meticulously set out the Oklahoma defendants' continuing, serious and knowing failures to assure that eligible children received health care services as required by the Medicaid Act. In determining the defendants had violated the equal access provision, the *OKAAP* court summarized:

> The testimony from providers and parents of class members alike was that recipients have great difficulty accessing needed health care services in Oklahoma. As plaintiffs established, the lack of physician participation in Medicaid forces class members either to wait for unreasonable periods of time to receive needed care or to travel long distances to find Medicaid participating providers, putting these children at *risk of harm or even death*.

> . . . The testimony at trial also demonstrated that providers are widely opting out of the Medicaid program or restricting their Medicaid caseloads.
>
> . . . Finally, defendants admitted at trial that reimbursement rates are inadequate and that the equal access provision is being violated.

OKAAP, 366 F. Supp. 2d at 1107 (emphasis added).

The evidence in the *OKAAP* case brought to light troubling facts concerning the state of health care for Oklahoma's young Medicaid population. For instance, the court found that one young Medicaid patient died while awaiting a delayed airway surgery. *OKAAP*, 366 F. Supp. 2d at 1100. At the time of the class certification hearing, named plaintiff Katelyn W. had been unable to secure a medically necessary prosthetic shoe insert to replace her amputated foot. *Id.* at 1088. The primary care physician ("PCP") of Jacob H., another named plaintiff, had attempted, without success, for approximately three years to find *any* Medicaid-participating facility to perform a necessary diagnostic sleep study. *Id.*

In this regard, the court found generally that "recipients in Oklahoma often experience long delays in obtaining appointments for provision of medically necessary care." *OKAAP*, 366 F. Supp. 2d at 1079. Access to neurological care was an area of particular concern. Pediatric Medicaid patients in Oklahoma City with seizure disorders were forced to wait

"*around a year* to be seen by a pediatric neurologist." *Id.* at 1067 (emphasis added). Some of these patients had poorly controlled seizures, and, as the court found, without the prompt care of a neurologist the seizures would negatively impact school performance, development, behavior, and the "'overall medical well-being'" of these children. *Id.* (quoting from Tr. Vol. I at 54:7-16). The court particularly noted the chilling account of one parent who told of being forced to drive her daughter for four hours to see a pediatric neurologist, and her daughter's experiencing a severe seizure *en route*. *Id.*

At the time of trial, office-based ear, nose and throat ("ENT") specialists in Oklahoma simply refused to treat children on Medicaid. *OKAAP*, 366 F. Supp. 2d at 1067-68. "The lack of Medicaid participation by private practice ENT specialists . . . created 'almost a crisis situation' at the [Oklahoma University] Medical Center in Oklahoma City." *Id.* at 1068 (internal quotation omitted). Dr. Richard Ranne, a pediatric thoracic surgeon in Tulsa, described access to orthopedists who accept Medicaid as "extremely poor." *Id.* at 1069. The court noted the testimony of another Tulsa pediatrician regarding "a six-week ordeal his office encountered attempting, without success, to secure an orthopedic consult for a four-year-old girl with a fractured toe." *Id.* at 1069.

Statistical and anecdotal evidence alike showed significant disparities between access to care under Medicaid when compared with access under private

plans. Survey data showed that only 34% of Oklahoma's pediatricians participated fully in the Medicaid program, while 69% of Oklahoma's pediatricians accepted all new privately insured patients. *OKAAP*, 366 F. Supp. 2d at 1063. The many physicians who testified at trial corroborated these statistics. A pediatric neurologist, who had ceased participation in Medicaid, testified that children on Medicaid did not have the same access to neurological services provided to children with private insurance "because of low or nonexistent Medicaid reimbursement." *Id.* at 1067. Another pediatrician testified that while access to ENT specialists was extremely poor for Medicaid patients, children with private insurance had "no problems" accessing ENT services. *Id.* at 1068.

Consistent with the results of the recent national survey conducted by the GAO, the *OKAAP* court found that approximately ninety-three percent (93.2%) of Oklahoma's pediatricians reported that low reimbursement is a "very important" reason they would limit their participation in the Medicaid program. *OKAAP*, 366 F. Supp. 2d at 1075. From 1995 through December 31, 2003, provider reimbursement under Oklahoma's Medicaid fee-for-service schedule never exceeded 72% of Medicare. *Id.* at 1059. By contrast, under commercial plans, Oklahoma physicians were reimbursed at rates of 130% to 180% of Medicare. *Id.* at 1060. As the CEO of Oklahoma's Medicaid agency candidly admitted, Oklahoma's Medicaid physician reimbursement rates

"are low, were low, and that this is a factor that makes it difficult to recruit physicians." *Id.* at 1075.

3. *Health Care for All v. Romney*

The *Health Care for All* case involved claims that responsible officials had failed to meet the dental needs, to the extent required by the Medicaid Act, of children and adults enrolled in Massachusetts' Medicaid program.[16] *See* 2005 WL 1660677. The court's findings revealed an absence of adequate access to mandatory dental care under Massachusetts' Medicaid program. *See, e.g., id.* at *2-7.

First, the court found that "[e]ach testifying plaintiff confronted hardships in identifying [Medicaid] participating dentists, obtaining appointments for dental care and receiving quality services." *Id.* at *2. One plaintiff, Ms. Curtis, worked diligently to find a single dental office willing to accept her Medicaid-enrolled children, only to subsequently discover that single dental office had closed its doors to Medicaid beneficiaries. *Id.* at *2. By the time Ms. Curtis had put together the money to pay out of pocket for her children to be seen by a solo practitioner, her sons had over 13 cavities. *Id.* Another young Medicaid beneficiary suffered an infected molar and could not

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[16] While the allegations made by the plaintiffs in *Health Care for All* factually resemble an equal access claim, the plaintiffs brought their claims under the Medicaid Act's "reasonable promptness" provision, 42 U.S.C. § 1396a(a)(8).

attend school, eat or sleep due to the pain until a Medicaid-participating dentist could be located to extract the tooth. *Id.* at *3. The court found that a mother searched for two months to identify an oral surgeon who accepted Medicaid and would perform extractions for her son whose permanent teeth were not developing properly. *Id.*

Second, the court relied upon statistical evidence that *86%* of licensed dentists in Massachusetts refused to accept Medicaid patients. *Id.* at *3.

Third, and importantly, the *Health Care for All* court compared access to dental care under Medicaid with access under Delta Dental, a commercial plan. *See, e.g., id.* at *5. Specifically, the Commonwealth defendants' own statistics showed that only slightly more than 30% of Medicaid-enrolled children received at least one dental visit each year for the years 2001, 2002, and 2003. *Id.* In contrast, 80 to 85% of children covered by Delta Dental had accessed such dental care. *Id.*

Fourth, the court found a clear connection between low Medicaid reimbursement and inadequate dental care. At the time of trial, Medicaid dental rates were "dramatically below . . . market levels" such that Medicaid-participating dentists could cover only about 75% of their costs. *Id.* at *4. In particular, plaintiffs established that Medicaid reimbursement rates were "so low that private dentists could not afford to treat enrollees who, thus, either received dental care only after much delay or not at all." *Id.* at *11.

D. The Availability of Judicial Remedies for Violations of the Equal Access Provision is Both Legally Mandated and Vital to Upholding the Rule of Law and Beneficiaries' Rights

Congress expected that courts would enforce § 1396a(a)(30)(A). *See, e.g., Pennsylvania Pharmacists Ass'n,* 283 F.3d at 541 (then-Judge Alito discussing legislative history and observing that "statement certainly suggests that the Committee anticipated that some class of plaintiffs would be able to sue to enforce Section 30(A). . . ."). The grievous deficiencies within the Illinois, Oklahoma and Massachusetts Medicaid programs would likely never have been addressed had the *Memisovski, OKAAP* and *Health Care for All* cases not been filed and prosecuted. All indications are that, without court intervention, the Medicaid programs in those states would have simply languished in perpetual noncompliance while beneficiaries suffered without recourse. As shown, the only effective enforcement tool available to the Secretary of HHS – revocation of a state's federal funding (*see* 42 U.S.C. § 1396c) – is the administrative equivalent of a nuclear bomb. "[A] funds cutoff is a drastic remedy with injurious consequences to the supposed beneficiaries of the Act." *Pennhurst State Sch. & Hosp. v. Halderman,* 451 U.S. 1, 52 (1981) (White J., dissenting). That is, were the Secretary to revoke funding of a State's Medicaid program for noncompliance with the equal access mandate, recipients would lose health care coverage altogether, turning a crisis into a catastrophe.

This leaves the federal courts as the only meaningful option. With no access to the courts, suffering beneficiaries will have no viable means for remedial relief. In addition, those state officials responsible for noncompliant Medicaid programs would never be called to task in contravention of fundamental rule of law principles. The classic American formulation of these principles can be traced back to John Adams and his Declaration of Rights in the Massachusetts Constitution of 1780. Article XXX applied the doctrine of separation of powers to the government of the Commonwealth " . . . to the end it may be a government of laws and not of men." This Court has since broadly recognized this "maxim." *Truax*, 257 U.S. at 332.

The rule of law doctrine applies with particular force to governmental bodies – even states – whose very existence depends on this country's laws and the respect of the population for those laws. Justice Brandeis eloquently stated the general principle:

> In a government of laws, existence of the government will be imperiled if it fails to observe the law scrupulously. Our government is the potent, the omnipresent teacher. For good or ill, it teaches the whole people by its example. Crime is contagious. If the government becomes a lawbreaker, it breeds contempt for law; it invites every man to become a law unto himself; it invites anarchy. . . . Against that pernicious doctrine this court should resolutely set its face.

Olmstead v. United States, 277 U.S. 438, 485 (1928) (Brandeis, J., dissenting). In *Marbury v. Madison*, Justice Marshall famously addressed the subordination of public officials to the rule of law as follows: "where a specific duty is assigned by law, and individual rights depend upon the performance of that duty, it seems . . . clear that the individual who considers himself injured, has a right to resort to the laws of his country for a remedy." 5 U.S. 137, 166 (1803) (emphasis added).

The equal access mandate is not being observed scrupulously. On the contrary, it is evident that the mandate is being violated by states on a wide scale. And, at the very least, the equal access provision of § 1396a(a)(30)(A) assigns a duty of performance to the states which is necessary in assuring that individual rights – such as the right to receive medically necessary services under the EPSDT provisions – are realized. Without an adequate network of health care providers willing to accept Medicaid patients, recipients will not receive the services guaranteed by the Medicaid Act; and without adequate payments to providers, there will not be enough providers willing to accept Medicaid patients. The specific duties assigned to responsible governmental officials by the equal access provision are central to beneficiaries' rights and well-being. If recipients are barred from holding government officials to account for shirking their legal duties, those officials will escape the rule of law, and suffering recipients will be denied the "right to resort to the laws of this country for a remedy" as envisioned by the *Marbury* Court.

The remedial powers of the federal courts offer genuine hope to the millions of Medicaid beneficiaries without access to prompt and quality medical or dental services. In particular Medicaid Act cases where plaintiffs have been successful in prosecuting or settling their claims, courts have been able to construct effective remedial orders. Courts have issued preliminary injunctions in equal access cases to prevent Medicaid payment rate cuts where states have failed to make findings as to the impact that such cuts would have on access. *See, e.g., Ark. Med. Soc'y v. Reynolds,* 834 F. Supp. 1097, 1103 (E.D.Ark. 1992); *Long Term Care Pharm. Alliance v. Ferguson,* 260 F. Supp. 2d 282 (D.Mass. 2003), *rev'd on other grounds, Long Term Care Pharm. Alliance v. Ferguson,* 362 F.3d 50 (1st Cir. 2004). These preliminary injunctions curtailed potentially disastrous cuts in Medicaid provider rates. Had these courts not been empowered to act, there would have been no remedy at all.

CONCLUSION

All of the considerations discussed above weigh in favor of a right to sue, because (a) violation of the equal access requirement has been epidemic since the statute was passed 20 years ago, (b) the federal government has shown not the slightest interest in enforcing the law, and (c) even if, hypothetically, the federal government were interested in enforcing the law, its means of doing so would probably be ineffective in meeting the overall Medicaid goal of providing

medical care for the poor and needy. If it is otherwise, the rule of law will be eroded, and "equal access" will remain an unfulfilled promise.

Respectfully submitted,

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In the Supreme Court of the United States

TOBY DOUGLAS, Director, Department of Health Care Services, State of California,

v.

INDEPENDENT LIVING CENTER OF SOUTHERN CALIFORNIA, INC., a Nonprofit Corporation, *et al.*

TOBY DOUGLAS, Director, Department of Health Care Services, State of California,

v.

CALIFORNIA PHARMACISTS ASS'N, *et al.*

TOBY DOUGLAS, Director, Department of Health Care Services, State of California,

v.

SANTA ROSA MEMORIAL HOSPITAL, *et al.*,

On Writ of *Certiorari* to the U.S. Court of Appeals for the Ninth Circuit

BRIEF FOR APA WATCH AS *AMICUS CURIAE* SUPPORTING PETITIONERS

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QUESTION PRESENTED

Under the Medicaid Act, a state that accepts federal Medicaid funds must adopt a state plan containing methods and procedures to "safeguard against unnecessary utilization of ... [Medicaid] services and ... assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available ... at least to the extent that such care and services are available to the general population." 42 U.S.C. §1396a(a)(30)(A). The Ninth Circuit, along with virtually all of the circuits to have considered the issue since this Court's decision in *Gonzaga University v. Doe*, 536 U.S. 273 (2002), concluded that this provision is not privately enforceable by providers or beneficiaries under 42 U.S.C. §1983, *inter alia*, because it does not confer any "rights" on providers or beneficiaries, and because it requires balancing of indeterminate and potentially conflicting policy objectives that are "ill-suited" for judicial enforcement. Nonetheless, the Ninth Circuit held that such considerations were irrelevant in the present cases, where respondents are proceeding under the Supremacy Clause rather than under §1983.

The question presented is:

Whether Medicaid recipients and providers may maintain a cause of action under the Supremacy Clause to enforce §30(A) by asserting that the provision preempts a state law that may reduce payments to providers?

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INTEREST OF *AMICUS CURIAE*[1]

Amicus curiae APA Watch is a nonprofit membership corporation headquartered in McLean, Virginia. APA Watch has participated as *amicus curiae* before this Court and the Courts of Appeals on third-party enforcement and justiciability issues. *See, e.g., Stormans Inc. v. Seleky*, No. 07-36039 (9th Cir.) (third-party justiciability); *Envtl. Defense v. Duke Energy Corp.*, No. 05-848 (U.S.) (third-party enforcement), *Astra USA, Inc. v. Santa Clara County, Cal.*, No. 09-1273 (U.S.) (third-party federal common-law cause of action). Although the third-party enforcement here does not directly affect APA Watch members, the premature second-guessing of agency enforcement and disrupting the contracting parties' expectations present an issue of fairness on which APA Watch seeks to comment. Moreover, because the litigants have not fully briefed the plaintiffs' standing, APA Watch's perspective on third-party justiciability could aid the Court on a jurisdictional issue antecedent to the parties' merits

---

[1] This *amicus* brief is filed with written consent of all parties; the written letters of consent from petitioner and respondents have been lodged with the Clerk of the Court. Pursuant to Rule 37.6, counsel for *amicus curiae* authored this brief and no counsel for a party authored this brief in whole or in part, nor did any person or entity other than the *amicus* and its counsel make a monetary contribution to the preparation or submission of this brief.

arguments. For these reasons, APA Watch respectfully files this *amicus* brief.

FACTUAL AND LEGAL BACKGROUND

In these three consolidated cases, a variety of plaintiffs (respondents here and, collectively, "Providers") sought and obtained a preliminary injunction against California's implementation and planned implementation of the Medicaid statute, 42 U.S.C. 1396 *et seq.* *Amicus* APA Watch adopts the facts as set forth in petitioner California's brief, and sets out the following legal background relevant to APA Watch's argument that the Providers lack standing.

Enforcement of Spending-Clause Legislation

Courts analogize Spending-Clause programs to contracts struck between the government and recipients, with the affected public as third-party beneficiaries. *Barnes v. Gorman,* 536 U.S. 181, 186 (2002); *Indiana Protection & Advocacy Services v. Indiana Family & Social Services Admin.,* 603 F.3d 365, 386 (7th Cir. 2010); *Bossier Parish School Bd. v. Lemon,* 370 F.2d 847, 850 (5th Cir. 1967). To regulate recipients based on their accepting federal funds, Congress must express Spending-Clause conditions unambiguously. *Gorman,* 536 U.S. at 186. With the required notice, recipients may face enforcement for violations. *Id.* at 187-89. Without the required notice, they do not.

Medicaid Statute

Established in 1965, Medicaid is a cooperative federal-state program that provides medical care to needy individuals. *Wilder v. Virginia Hosp. Ass'n,* 496 U.S. 498, 502 (1990). State participation in Medicaid is voluntary under the Spending Clause,

but participating States agree to comply with requirements imposed by the Medicaid statute and the implementing regulations of the Department of Health & Human Services ("HHS").

To qualify for federal funds, participating States must submit to HHS and receive approval of "a plan for medical assistance" on the nature and scope of that State's Medicaid program. 42 U.S.C. §1396a(a); 42 C.F.R. §430.10. In addition, after the initial approval, States may submit a "State plan amendment" or "SPA" to revise the State plan. 42 C.F.R. §430.12, as California has done here. If HHS denies the SPA (as HHS has done here), the State may request reconsideration of that disapproval (as California has done here), which initiates an administrative process including a formal hearing – including the opportunity for public participation – and the eventual opportunity for judicial review directly in the Court of Appeals for the appropriate Circuit. 42 C.F.R. 430.18, 430.60, 430.76, 430.102(c); 42 U.S.C. 1316(a)(3). These required processes have not run their course.

Federal Common Law

"This Court has consistently held that federal law governs questions involving the rights of the United States arising under nationwide federal programs." *U.S. v. Kimbell Foods, Inc.*, 440 U.S. 715, 726 (1979). Thus, "[f]ederal law typically controls when the Federal Government is a party to a suit involving its rights or obligations under a contract." *Boyle v. United Tech. Corp.*, 487 U.S. 500, 519 (1988); *cf. Empire Healthchoice Assur., Inc. v. McVeigh*, 547 U.S. 677, 691 (2006) ("Court has made clear that uniform federal law need not be applied to all questions in federal government litigation, even in

cases involving government contracts") (internal quotations omitted). For *private enforcement* of a federal contract or program, however, a uniform federal rule of decision is not required if the claim "will have *no direct effect upon the United States or its Treasury.*" *Boyle*, 487 U.S. at 520 (*quoting Miree v. DeKalb County*, 433 U.S. 25, 29 (1977)) (emphasis in *Boyle*). While this Court typically applies federal common law to litigation involving the federal government, it does not necessarily do so for private enforcement of the same federal provisions.

"Controversies directly affecting the operations of federal programs, although governed by federal law, do not inevitably require resort to uniform federal rules." *Kimbell Foods*, 440 U.S. at 727-28. This Court could adopt a federal rule of decision that looks to state law: "when there is little need for a nationally uniform body of law, state law may be incorporated as the federal rule of decision." *Kimbell Foods*, 440 U.S. at 728. Indeed, "[t]he prudent course ... is often to adopt the readymade body of state law as the federal rule of decision until Congress strikes a different accommodation." *McVeigh*, 547 U.S. at 691-92 (internal quotation omitted). In other words, notwithstanding that federal law applies, the federal rule of decision nonetheless could be "*See the state rule.*"

Finally, "federal programs that by their nature are and must be uniform in character throughout the Nation necessitate formulation of controlling federal rules." *Kimbell Foods*, 440 U.S. at 728 (*citing United States v. Yazell*, 382 U.S. 341, 354 (1966)) (interior quotations omitted). "[A]bsent some congressional authorization to formulate substantive rules of decision, federal common law exists only in such

narrow areas as those concerned with the rights and obligations of the United States, interstate and international disputes implicating conflicting rights of States or our relations with foreign nations, and admiralty cases." *Texas Industries, Inc. v. Radcliff Materials, Inc.*, 451 U.S. 630, 641 (1981) (footnotes omitted). Generally, therefore, this Court has discretion "[w]hether to adopt state law or to fashion a nationwide federal rule," *Kimbell Foods*, 440 U.S. at 728, based on "a variety of considerations ... relevant to the nature of the specific governmental interests and to the effects upon them of applying state law." *U.S. v. Standard Oil Co.*, 332 U.S. 301, 310 (1947). In sum, this Court makes a case-by-case determination on the need for uniform federal rules, based on the totality of the circumstances.

In light of the highly technical nature of both the Medicaid statute and its implementing regulations and of the potentially national – albeit piecemeal – scope of this litigation through similarly situated entities in other States, *amicus* APA Watch respectfully submits that this Court should adopt uniform federal rules of decision. As it happens, however, the rules would be the same under California or federal law.

SUMMARY OF ARGUMENT

As signaled by the preceding subsection, *amicus* APA Watch submits that this case calls upon this Court to adopt a rule of decision under the federal common law. While the parties focus on the availability of a third-party cause of action to enforce a provision of Medicaid's reimbursement regime, *amicus* APA Watch respectfully submits that this Court first must adopt a federal rule of decision for third-party beneficiaries' standing to enforce the

contractual aspects of a recipient's obligations to the United States under the Spending Clause. Because it is antecedent to the merits question presented here, the standing inquiry assumes *arguendo* the plaintiffs' merits views (*i.e.*, that the Providers may maintain suit under the Supremacy Clause to enforce their particular provision of the Medicaid puzzle) and then asks whether those plaintiffs meet the constitutional and prudential tests for standing. Because it is integral to federal jurisdiction, the standing inquiry comes first. If the Providers lack standing, the case must be dismissed for lack of jurisdiction under FED. R. CIV. P. 12(b)(1).

Section I argues that this Court – like all federal courts – has an independent duty to consider standing, whether or not the parties have raised it. Concurring with California (Opening Br. at 49-53), Section II argues that the Providers do not have third-party standing to enforce the rights of HHS or the United States, both because they lack the required close relationship and because nothing hinders the federal government's enforcing its own rights. Finally, and notwithstanding that this Court must assume the Providers' non-frivolous merits views to evaluate jurisdiction, Section III argues that the Providers lack standing for the relief that they seek because *even the United States* could not obtain the relief that the Providers seek at this juncture, before the required administrative process unfolds. What the promisee lacks a vested right to enforce directly, a third-party beneficiary lacks a cognizable right to enforce indirectly, regardless of whether that third party could enforce the contract after the right vests for the promisee.

ARGUMENT

Although this Court's "normal role is to interpret law created by others and not to prescribe what [the law] shall be," *Danforth v. Minnesota,* 552 U.S. 264, 290 (2008) (internal quotation omitted), "this Court has ultimate authority to determine and declare" the federal common law. *Taylor v. Sturgell,* 553 U.S. 880, 891 (2008). Here, federal law obviously applies – under Article III for jurisdiction and under Medicaid's express terms for the merits – but "[t]he more difficult task ... is giving content to this federal rule." *Kimbell Foods,* 440 U.S. at 727. Although it presents no position on the merits, *amicus* APA Watch respectfully submits that this litigation must be dismissed: the Providers have no cognizable right, much less a right of action, under Medicaid.

I. CALIFORNIA CANNOT WAIVE THE PROVIDERS' LACK OF STANDING

Article III limits federal courts to "cases" and "controversies," U.S. CONST. art. III, §2, which requires an actual or imminent "injury in fact" to a cognizable interest. *Lujan v. Defenders of Wildlife,* 504 U.S. 555, 560 (1992). Specifically, constitutional standing presents a tripartite test: "an invasion of a *legally protected interest*" of the plaintiff, caused by the defendants, and redressable by a court. *Defenders of Wildlife,* 504 U.S. at 560-62 (emphasis added).

Moreover, even if California had not contested standing, litigants cannot confer federal jurisdiction by consent or waiver: "no action of the parties can confer subject-matter jurisdiction upon a federal court." *Insurance Corp. of Ireland v. Compagnie des Bauxites de Guinee,* 456 U.S. 694, 702 (1982);

FW/PBS, Inc. v. City of Dallas, 493 U.S. 215, 231 (1990); *Steel Co. v. Citizens for a Better Env't*, 523 U.S. 83, 95 (1998). To the contrary, because it goes to the Article III "power of the court to entertain the suit," standing "is *the threshold question* in every federal case." *Warth v. Seldin*, 422 U.S. 490, 499 (1975) (emphasis added). "'Without jurisdiction the court cannot proceed at all in any cause. Jurisdiction is power to declare the law, and when it ceases to exist, the only function remaining to the court is that of announcing the fact and dismissing the cause.'" *Steel Co.*, 523 U.S. at 94 (*quoting Ex parte McCardle*, 74 U.S. (7 Wall.) 506, 514 (1868)). Consequently, the Provider's standing is antecedent to the cause-of-action question on which the parties join. *Steel Co.*, 523 U.S. at 89-90:

> *It is firmly established in our cases that the absence of a valid ... cause of action does not implicate subject-matter jurisdiction,* i.e., *the courts' statutory or constitutional* power *to adjudicate the case.*

Id. at 89 (emphasis in original); *Northwest Airlines, Inc. v. County of Kent*, 510 U.S. 355, 365 (1994) ("[t]he question whether a federal statute creates a claim for relief is not jurisdictional"). Under its precedents – and its constitutional jurisdiction – this Court must evaluate standing before the cause-of-action issue in the Question Presented. If the Providers lack standing, that ends the inquiry, without answering the question.

II. PROVIDERS CANNOT LITIGATE THE INJURIES OF HHS

It is, of course, "axiomatic" that a "litigant first must clearly demonstrate that [it] has suffered

an injury in fact in order to assert Article III standing to sue." *Wyoming v. Oklahoma*, 502 U.S. 437, 465 (1992) (interior quotations omitted). Because plaintiffs bear the burden of establishing their standing, federal courts "presume that [they] lack jurisdiction unless the contrary appears affirmatively from the record." *Renne v. Geary*, 501 U.S. 312, 316 (1991). As explained in the next section, the Providers lack standing under Medicaid.

Significantly, the Providers lack standing to litigate the United States' injuries. A plaintiff can assert the rights of absent third parties only if the plaintiff itself has constitutional standing, the plaintiff and the absent third parties have a "close" relationship, and a sufficient "hindrance" keeps the absent third party from protecting its own interests. *Kowalski v. Tesmer*, 543 U.S. 125, 128-30 (2004) (*citing Powers v. Ohio*, 499 U.S. 400, 411 (1991)). Even assuming *arguendo* that the Providers could establish constitutional standing on their own, they would fail the second and third prongs of the test for litigating the United States' injuries: (a) they lack the requisite close relationship with the federal government, and (b) nothing hinders HHS from eventually proceeding against California if the Providers are correct on the merits.

III. THIRD-PARTY BENEFICIARIES LACK STANDING TO ENFORCE RIGHTS THAT HAVE NOT VESTED IN THE PROMISEE

At the outset, only *intended* beneficiaries have standing to enforce an agreement. *Karo v. San Diego Symphony Orchestra Ass'n*, 762 F.2d 819, 821-22 (9th Cir. 1985); *Garcia v. Truck Insurance Exchange*, 36 Cal.3d 426, 436-37 (1984). Those who are not intended beneficiaries are mere interlopers who lack

standing to sue to enforce other parties' contract. *U.S. v. Andreas*, 216 F.3d 645, 664 (7th Cir. 2000) (those "not parties or third-party beneficiaries ... do not have standing to enforce the terms of [an] agreement); *More v. Churchill*, 155 Cal. 368, 369-70 (1909); *cf. Gart v. Cole*, 263 F.2d 244, 250-51 (2d Cir. 1959) (individual landowners and tenants lack standing to enforce sponsorship agreements under the Housing Act, which are designed to benefit the public at large). Significantly, even intended beneficiaries need not have the intended right to enforce the bargain, particularly for government promisees like HHS:

> *The distinction between an intention to benefit a third party and an intention that the third party should have the right to enforce that intention is emphasized where the promisee is a governmental entity.*

Astra USA, Inc. v. Santa Clara County, Cal., __ U.S. __, 2011 WL 1119021, 5 (2011) (*quoting* 9 J. Murray, Corbin on Contracts §45.6, p. 92 (rev. ed. 2007)). Federal agencies, of course, are bound by their own statutes and regulations, which can pose conditions precedent to enforcement in court. Foregoing that process, the Providers here propose to "spawn a multitude of dispersed and uncoordinated lawsuits by [beneficiaries]," *Astra*, __ U.S. __, 2011 WL 1119021, at 5. California – and the other States – never agreed to that, and federal law does not sanction it.

Significantly, even *intended* third-party beneficiaries "generally have no greater rights in a contract than does the promise[e]." *United Steelworkers of Am. v. Rawson*, 495 U.S. 362, 375 (1990); *Holbrook v. Pitt*, 643 F.2d 1261, 1273 n.24

(7th Cir. 1981) ("tenants, as third-party beneficiaries, are bound by the terms and conditions of the Contracts"); *Avatar Exploration, Inc. v. Chevron, U.S.A., Inc.*, 933 F.2d 314, 318 (5th Cir. 1991) ("[a]s third party beneficiaries, their rights under the contract could not exceed [the promisee's] rights"); *BAII Banking Corp. v. UPG, Inc.*, 985 F.2d 685, 697 (2d Cir. 1993) ("third-party beneficiary ... possessed no greater right to enforce a contract than the actual parties to the contract"), which links the third-party beneficiaries' rights to the same conditions as the promisee's rights. RESTATEMENT (SECOND) OF CONTRACTS §304 comment b. To the extent that the Providers depend on California's Medicaid obligations to HHS, the Providers' rights are subject to the same conditions precedent as HHS's rights. *What HHS could not do directly as the promisee, the Providers cannot do indirectly as a third-party beneficiary.*

Under *Miree v. DeKalb County*, 433 U.S. 25, 28 (1977), federal courts can look to state law for third-party beneficiaries' standing to enforce federal obligations. California follows the RESTATEMENT (SECOND) OF CONTRACTS, *Martinez v. Socoma Companies, Inc.*, 11 Cal.3d 394, 401-02, 404-05 (1974) (citing RESTATEMENT OF CONTRACTS and then-tentative drafts of the RESTATEMENT (SECOND) OF CONTRACTS); *Outdoor Services, Inc. v. Pabagold, Inc.*, 185 Cal.App.3d 676, 683-84 (Cal. App. 1986) (citing RESTATEMENT (SECOND) OF CONTRACTS), as do most other states. *See, e.g., Guy v. Leiderbach*, 501 Pa. 47, 459 A.2d 744, 750-52 (Pa. 1983); *Joseph v. Hospital Service Dist. No. 2*, 939 So.2d 1206, 1213 (La. 2006).

An intended beneficiary must assert a vested right, *Karo*, 762 F.2d at 822 ("he must be seeking to

enforce a right that is personal to him and vested in him at the time of the suit"), without which "[h]e does not have standing to sue as a third party beneficiary because he had no vested rights." *Karo*, at 824; *Peabody v. Weider Publications, Inc.*, 260 Fed.Appx. 380, 383 (2d Cir. 2008) ("[b]ecause the condition precedent never came to fruition, Peabody's rights ... never vested") (non-precedential summary order). A "vested right" is one "not subject to a condition precedent." *In re Marriage of Bouquet*, 16 Cal.3d 583, 591 n.7 (1976); *Skookum Oil Co. v. Thomas*, 162 Cal. 539, 545 (1912) ("[n]either will equity relieve such [party] who ... has not fulfilled conditions precedent to the vesting of his right of action"); *Knudson v. City of Ellensburg*, 832 F.2d 1142, 1147 (9th Cir. 1987). Given that HHS could not have brought this action *under Medicaid* without completing the administrative prerequisites, neither HHS nor California intended third-party beneficiaries to enforce Medicaid – or, really, to *short-circuit* Medicaid – without satisfying those prerequisites.[2] Under the circumstances, the Providers lack standing to sue.

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[2] *See, e.g., Glock v. Howard & Wilson Colony Co.*, 123 Cal. 1, 16-17 (1898) (when a "contract is made to depend upon a condition precedent" and "[b]y its terms no right is to vest ... until certain acts ... have been done by [a party]," "a court of equity no more than a court at law will relieve [the party], under such circumstances ... in the absence of an equitable showing to excuse his default"); *Chen v. Chen*, 586 Pa. 297, 311-13, 893 A.2d 87, 96 (Pa. 2006); *OEC-*

(Footnote cont'd on next page)

Unmet conditions precedent can affect both standing under Rule 12(b)(1) and failure to state a claim under Rule 12(b)(6). For example, Louisiana law for stipulations *pour autrui* (*i.e.*, third-party beneficiary contracts) suggests that failure to meet the promisee's conditions precedent renders third-party beneficiaries unable to state a claim. *Shaw Constructors v. ICF Kaiser Eng'rs, Inc.*, 395 F.3d 533, 540 & n.15 (5th Cir. 2004); *Kane Enter. v. MacGregor (USA) Inc.*, 322 F.3d 371, 375 (5th Cir. 2003). Even if unmet conditions precedent implicated only Rule 12(b)(6) *for promisees*,[3] they nonetheless would

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Diasonics, Inc. v. Major, 674 N.E.2d 1312, 1314-15 (Ind. 1996); *Connecticut State Medical Soc. v. Oxford Health Plans (CT), Inc.*, 272 Conn. 469, 476-78, 863 A.2d 645, 649-50 (Conn. 2005).

[3] Numerous statutory regimes set conditions precedent to private enforcement to notify the putative defendant of alleged violations and to provide an opportunity to resolve them. *Zipes v. Trans World Airlines, Inc.*, 455 U.S. 385, 398 (1982); *Friends of the Earth, Inc. v. Laidlaw Envtl. Serv. (TOC), Inc.*, 528 U.S. 167, 174-75 (2000); *Hallstrom v. Tillamook County*, 493 U.S. 20, 32-33 (1989). Regardless of "whether the notice provision is jurisdictional or procedural," private enforcement is "barred" and "must be dismissed" if it commenced prior to the required notice. *Hallstrom*, 493 U.S. at 32-33. Even if not jurisdictional under constitutional standing, that is fatal under statutory standing,

(Footnote cont'd on next page)

implicate jurisdiction for third-party beneficiaries, who lack standing to enforce non-vested rights. *Conoco, Inc. v. Republic Ins. Co.*, 819 F.2d 120, 123-24 (5th Cir. 1987); *Palma v. Verex Assur., Inc.*, 79 F.3d 1453, 1458 (5th Cir. 1996). Without the conditions precedent to Medicaid enforcement, the Providers have no legally protected interest in Medicaid reimbursement and thus no standing here.

Whether this Court adopts a federal rule of decision or relies on California law under *Miree*, third-party beneficiaries plainly lack standing to enforce contractual provisions that even the promisee could not enforce without having met the conditions precedent to contractual enforcement.

CONCLUSION

For the foregoing reasons, this Court should hold that the Providers lack standing to bring their third-party claim to enforce Medicaid.

(Footnote cont'd from previous page.)

which this Court also can address at this stage. *Ortiz v. Fibreboard Corp.*, 527 U.S. 815, 830-31 (1999).

May 26, 2011

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RECORD
AND
BRIEFS

Nos. 09-958, -1158, and 10-283

In the Supreme Court of the United States

TOBY DOUGLAS, DIRECTOR, CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES, *Petitioner*,
v.
INDEPENDENT LIVING CENTER OF SOUTHERN CALIFORNIA, INC., *Respondent*.

TOBY DOUGLAS, DIRECTOR, CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES, ET AL., *Petitioners*,
v.
CALIFORNIA PHARMACISTS ASSOCIATION, ET AL., *Respondents*.

TOBY DOUGLAS, DIRECTOR, CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES, *Petitioner*,
v.
SANTA ROSA MEMORIAL HOSPITAL, ET AL., *Respondents*.

On Writs of Certiorari to the United States Courts of Appeals for the Ninth Circuit

BRIEF OF THE CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENTS

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BRIEF OF THE CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA AS *AMICUS CURIAE* IN SUPPORT OF RESPONDENTS

INTEREST OF THE *AMICUS CURIAE*[1]

The Chamber of Commerce of the United States of America (the Chamber) is the world's largest business federation. The Chamber represents 300,000 direct members and indirectly represents the interests of more than three million companies and professional organizations of every size, in every industry, and from every region of the country. An important function of the Chamber is to represent the interests of its members in matters before Congress, the Executive Branch, and the courts. To that end, the Chamber regularly files *amicus curiae* briefs in—or itself initiates—cases that raise issues of vital concern to the Nation's business community.

This is such a case. The Chamber's members depend on the robust enforcement of conflict preemption principles as protection against state and local mandates that interfere or conflict with requirements imposed by federal law. The Supremacy Clause of the Constitution, which is the fountainhead of the doctrine of conflict preemption,

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[1] The parties' letters of consent to the filing of this brief have been filed with the Clerk. Under this Court's Rule 37.6, *amicus curiae* states that no counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. No person or entity, other than the *amicus curiae* or its counsel, has made a monetary contribution to this brief's preparation or submission.

serves a vital structural role in our Nation's government and economy by (a) protecting all federal laws and programs against interference by subordinate governments; and (b) eliminating regulatory burdens placed on the formation and operation of unified national markets for goods and services. Those crucial societal benefits depend on the availability of effective means for injured businesses and other litigants to enforce the Supremacy Clause in the courts—the primary institutions to which the Framers assigned this important responsibility. In this case, petitioners seek to weaken or eliminate a significant, time-tested method for such enforcement: the cause of action for equitable relief under the Supremacy Clause.

The Chamber has relied on this cause of action in seeking to vindicate the interests of its members. See, *e.g.*, *Chamber of Commerce of the United States* v. *Whiting*, 131 S. Ct. 1968 (2011); *Chamber of Commerce of the United States* v. *Brown*, 554 U.S. 60 (2008). When not acting as a party, the Chamber has frequently supported such suits as an *amicus curiae*. See, *e.g.*, *Rowe* v. *New Hampshire Motor Transp. Ass'n*, 552 U.S. 364 (2008); *Watters* v. *Wachovia Bank, N.A.*, 550 U.S. 1 (2007); *Pharm. Research & Mfrs. of Am.* v. *Walsh*, 538 U.S. 644 (2003); *Crosby* v. *National Foreign Trade Council*, 530 U.S. 363 (2000); *Gade* v. *Nat'l Solid Wastes Mgmt. Ass'n*, 505 U.S. 88 (1992). Accordingly, the Chamber and its members have a substantial interest in ensuring that this Court correctly resolves the important issue presented here.

STATEMENT

The Supremacy Clause provides that "[t]his Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding." U.S. CONST., art. VI, cl. 2. The question presented by this case is whether the Supremacy Clause furnishes a cause of action for injunctive relief against state enactments that are preempted by federal law.

The federal statute involved here is the Federal Medicaid Act, which sets out "a cooperative federal-state program through which the Federal Government provides financial assistance to States so that they may furnish medical care to needy individuals." *Wilder* v. *Virginia Hosp. Ass'n*, 496 U.S. 498, 502 (1990). States that choose to accept federal funding must comply with certain requirements set out in the statute, as well as in regulations promulgated by the Secretary of Health and Human Services. California has accepted funding and is therefore bound by those requirements in administering the State's Medicaid program (known as "Medi-Cal").

In a series of lawsuits, various entities and individuals—including hospitals, pharmacies, pharmacists, adult day health centers, and individual Medicaid recipients—challenged several California statutes, each of which reduced Medicaid payment rates. The plaintiffs (respondents here) argued that, by ordering further successive reductions in California payment rates that *were already the lowest*

in the Nation on an average per-enrollee basis, the California statutes violated Section 30(A) of the Medicaid Act, 42 U.S.C. § 1396a(a)(30)(A). Section 30(A) provides, in relevant part, that States must take certain steps to "assure that payments" are not only "consistent with efficiency, economy, and quality of care" but also "sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area." In each of the cases, the district court ultimately entered a preliminary injunction against the challenged rate reduction, and the Ninth Circuit affirmed.

The two basic questions facing the Ninth Circuit were (1) whether the Supremacy Clause provided a cause of action for the respondents—Medicaid providers and recipients who face injury from the rate reductions—to seek injunctive relief on preemption grounds; and (2) whether the challenged California statutes imposing the rate reductions were in conflict with, and thus preempted by, the Medicaid Act. The Ninth Circuit answered both questions in the affirmative. This Court granted certiorari with respect to only the first question. As this case comes to the Court, then, it is undisputed that the challenged California statutes violate or directly conflict with Section 30(A) of the Medicaid Act.

SUMMARY OF ARGUMENT

The question presented is whether this Court should foreclose (or at least sharply curtail) an avenue of relief that has long been available: namely, a cause of action for equitable relief against preempted state laws. The Court should adhere to its

historical practice and continue to recognize the preemption cause of action. Furthermore, it should hold explicitly that this cause of action arises under the Supremacy Clause.

I. This conclusion is dictated by this Court's longstanding and consistent practice over almost 200 years. The Court has specifically held that there is federal jurisdiction over preemption claims. Moreover, the Court has routinely proceeded directly to the merits of such claims, frequently granting relief to plaintiffs requesting injunctive relief against preempted state or local laws without doubting that there was a valid cause of action. These decisions firmly establish the general availability of a private cause of action for prospective relief on preemption grounds.

Multiple lower courts and commentators have correctly recognized that this cause of action is rooted in the Supremacy Clause. This Court has also recognized the nexus, explaining that "the availability of prospective relief . . . gives life to the Supremacy Clause." *Green* v. *Mansour*, 474 U.S. 64, 68 (1985).

Petitioners mistakenly seek to impair that vitality by confining this cause of action to the parameters of the Court's Section 1983 and implied-cause-of-action jurisprudence. They cannot account, however, for the Court's different approach to preemption cases. Instead of applying the analytical frameworks it has developed in the Section 1983 and implied-cause-of-action contexts, the Court in preemption cases proceeds directly to the merits. This longstanding and consistent approach is justified, as the preemption

cause of action is different from these points of comparison in several crucial respects.

II. The history of the Supremacy Clause demonstrates that the Framers entrusted enforcement of federal supremacy to the courts, and that they regarded the Supremacy Clause as the effective means of accomplishing that objective. The Supremacy Clause was adopted to prevent States from flouting federal law. It was chosen over two alternatives—one that would have placed the responsibility for ensuring federal supremacy on the Executive Branch (by authorizing the Union to coerce noncompliant States with military force), and another that would have relied on affirmative action by Congress (by giving it a "negative" over state law). The Supremacy Clause was ultimately chosen because it was viewed as an adequate substitute for the Congressional negative; in other words, it was a potent, affirmative guarantee of federal supremacy, to be implemented by the courts. In recognizing the preemption cause of action, this Court is ensuring that the judiciary will continue to perform the role assigned to it by the Supremacy Clause.

Furthermore, this cause of action remains vitally important as a safeguard against widespread flouting of federal law by state and local governments. If credited, the petitioners' position would undermine the effectiveness of federal preemption. That, in turn, would harm businesses and consumers by undercutting the crucial systemic benefits of preemption, which include the promotion of regulatory uniformity, the flourishing of a unified national marketplace, and the enablement of national deregulatory policies.

III. Petitioners say that a cause of action should not be available in this case because the challenged California statutes do not directly regulate the respondents' conduct. Such a requirement would add little, however, because standing rules already ensure that only appropriate plaintiffs may bring preemption actions. Moreover, this limitation makes no sense because it would require courts to treat direct and indirect regulations differently even if they have the identical effect on the plaintiffs and are equally preempted. See *Geier* v. *American Honda Motor Co.*, 529 U.S. 861, 873 (2000) (rejecting analysis that would "further complicat[e] well-established pre-emption principles that already are difficult to apply").

Finally, the petitioners argue that the Supremacy Clause cause of action should be unavailable with respect to Spending Clause statutes, because such statutes resemble contracts more than ordinary legislation. That is squarely at odds with the Court's cases, which treat Spending Clause statutes as having fully preemptive force. Moreover, that contention is simply a preemption argument on the merits, rather than an argument concerning the existence of a cause of action. As such, it is irrelevant in this case.

ARGUMENT

The central issue in this case is whether this Court should decline to recognize an equitable right of action under the Supremacy Clause to enjoin California officials from implementing and enforcing state laws that violate or directly conflict with a provision of the Federal Medicaid Act, 42 U.S.C. § 1396a(a)(30)(A). Petitioners and their *amici*

correctly acknowledge that this Court's cases recognize a federal equitable cause of action to enjoin state laws preempted under the Supremacy Clause, at least in certain circumstances. See Brief of National Governors Ass'n et al., at 23-24 (recognizing "a right in equity to assert an anticipatory defense against the enforcement of a pre-empted State law") ("NGA Br."); Pet. Br. 43-44 & n.15 (same; recognizing as well that "the federal government may sue to enjoin state law that purportedly is preempted by federal law"); U.S. Br. 21 & n.7. For its part, the United States further acknowledges that this cause of action has "considerable historical grounding," is "well established," and "serves an important purpose in vindicating the supremacy of federal law." U.S. Br. 21 n.7.

Despite these concessions, petitioners and their *amici* repeatedly seek to cast doubt upon a line of this Court's cases that, as respondents demonstrate, extends back almost 200 years. See Brief of Respondents Santa Rosa Memorial Hospital et al., at 18-26 ("Santa Rosa Resp. Br."); Brief of Intervenor Respondents in No. 09-958 and *California Pharmacists* Respondents in No. 09-1158, at 20-31 ("*California Pharmacists* and Intervenor Resp. Br."); Brief for *Dominguez* Respondents in Case No. 09-1158, at 7-11 & App. 1a-11a (listing 61 decisions of this Court) ("*Dominguez* Resp. Br."). Petitioners' principal contention is that this cause of action should not be available when the preemption arises from a statute enacted under the federal Spending Clause.

This Court should reject that departure from longstanding practice. Proper resolution of this

question turns on the nature of the Supremacy Clause, not the particular statute at issue. The Supremacy Clause was intended as an affirmative guarantee that national law will be effective in displacing inconsistent state and local regulation. And it is undisputed that responsibility for enforcing that guarantee was vested in the judiciary; indeed, petitioners and their *amici* acknowledge that the Framers rejected alternative proposals that would have required Congress to serve as the arbiter of federal supremacy. Pet. Br. 38; NGA Br. 4, 14-16. And yet that is precisely what petitioners and their *amici* now urge in claiming that there is no cause of action under the Supremacy Clause (in this statutory context, at least)—if Congress does not affirmatively supply a *statutory* right of action, they say, then the *constitutional* guarantee of federal supremacy is merely hypothetical. But the Supremacy Clause flatly declares that federal law "*shall* be the supreme Law of the Land," U.S. CONST., art. VI, cl. 2 (emphasis added), not that it "ought" to be supreme if Congress so provides.

I. THIS COURT SHOULD UNAMBIGUOUSLY HOLD THAT A CAUSE OF ACTION EXISTS UNDER THE SUPREMACY CLAUSE FOR INJUNCTIVE RELIEF AGAINST PRE-EMPTED STATE LAWS

A. This Court's Decisions And Longstanding Practice Already Establish This Cause Of Action

Almost thirty years ago, in *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85 (1983), this Court addressed the question of federal jurisdiction over preemption claims. The Court explained that "[a] plaintiff who

seeks injunctive relief from state regulation, on the ground that such regulation is pre-empted by a federal statute which, by virtue of the Supremacy Clause of the Constitution, must prevail, thus presents a federal question which the federal courts have jurisdiction under 28 U.S.C. § 1331 to resolve." 463 U.S. at 96 n.14. That conclusion, which was emphatically reiterated in *Verizon Maryland Inc.* v. *Pub. Serv. Comm'n of Maryland*, 535 U.S. 635, 642 (2002), is rooted in a long line of authority stretching back at least to the seminal opinion in *Ex parte Young*, 209 U.S. 123 (1908). As a leading treatise observes: "The entire line of cases beginning with *Ex parte Young* establishes that in many circumstances a person confronted with efforts to apply state law may invoke federal question jurisdiction to restrain state officials on the ground of unconstitutionality of a state enactment. The version of unconstitutionality that arises from the preemptive effect the Supremacy Clause gives to federal statutes would seem to be no different." 13D C. WRIGHT & A. MILLER, FEDERAL PRACTICE & PROCEDURE § 3566, at 288 (3d ed. 2008) (footnotes omitted) ("WRIGHT & A. MILLER"); see also *Shaw*, 463 U.S. at 96 n.14 (citing *Ex parte Young*).

To be sure, the issue of subject matter jurisdiction may be distinguished from the cause-of-action inquiry. *Verizon*, 535 U.S. at 642-43. But it is noteworthy that in *Shaw*, where a group of employers claimed that two New York statutes were preempted by federal law, the Court proceeded directly to the merits, without ever questioning whether there was a valid cause of action. *Shaw*, 463 U.S. at 95-96. Indeed, the Court granted relief to the employers, holding that one of the statutes was at least partially preempted. *Id.* at 108-09. In so doing, the Court

unmistakably indicated that the employers had a valid cause of action.

Moreover, as respondents persuasively demonstrate, *Shaw* is part of a long line of cases in which the Court has allowed private parties to seek prospective relief against state officials on pre-emption grounds. See Santa Rosa Resp. Br. 18-26; *California Pharmacists* and Intervenor Resp. Br. 20-31; *Dominguez* Resp. Br. 7-11 & App. 1a-11a (listing 61 decisions of this Court). Even the United States, in siding with petitioners, is constrained to admit that this Court has "decided *dozens* of preemption claims against state officials on their merits in cases brought in federal court." U.S. Br. 9 (emphasis added). As respondents persuasively demonstrate, this line of cases in fact stretches back almost 200 years, to the Court's decision in *Osborn* v. *Bank of the United States*, 22 U.S. (9 Wheat.) 738 (1824). See Santa Rosa Resp. Br. 18-19 (discussing *Osborn*); *California Pharmacists* and Intervenor Resp. Br. 20-21 (same); *Dominguez* Resp. Br. 7-8 (discussing *Osborn* and other early cases).[2]

In short, through its decisions and consistent practice over almost 200 years, this Court has made clear that there is a generally available cause of action for parties who seek to enjoin state action on the ground that it is preempted. See R. FALLON, JR.,

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[2] Recent examples include *Rowe* v. *New Hampshire Motor Transp. Ass'n*, 552 U.S. 364 (2008) (Maine tobacco law), *Watters* v. *Wachovia Bank, N.A.*, 550 U.S. 1 (2007) (Michigan banking regulations), and *Arkansas Dep't of Health & Human Services* v. *Ahlborn*, 547 U.S. 268 (2006) (Arkansas law governing liens asserted against tort settlements by Medicaid recipients). Earlier examples could be effortlessly multiplied. See *Dominguez* Resp. Br. App. 1a-11a (collecting cases).

J. MANNING, D. MELTZER, & D. SHAPIRO, HART AND WECHSLER'S THE FEDERAL COURTS AND THE FEDERAL SYSTEM 807 (6th ed. 2009) (describing as "well-established" the "rule" that a cause of action exists "to enjoin state or local regulation that is preempted by a federal statutory or constitutional provision—and that such an action falls within the federal question jurisdiction") ("HART AND WECHSLER"). Unsurprisingly, the lower courts have uniformly followed suit and recognized such a cause of action. See *Indep. Living Ctr. of S. California, Inc.* v. *Shewry*, 543 F.3d 1050, 1058-59 (9th Cir. 2008) (collecting cases).

Although this Court has not explicitly identified the precise source of this cause of action, many lower courts and commentators have correctly concluded that it arises under the Supremacy Clause. As the Wright & Miller treatise notes, this is "[t]he best explanation of *Ex parte Young* and its progeny." 13D WRIGHT & MILLER, *supra*, § 3566, at 292. At least five circuits have adopted this view. See *Planned Parenthood of Houston and Southeast Tex.* v. *Sanchez*, 403 F.3d 324, 334 & n.47 (5th Cir. 2005); *Pharm. Research & Mfrs. of Am.* v. *Concannon*, 249 F.3d 66, 73 (1st Cir. 2001), *aff'd sub nom. Pharm. Research & Mfrs. of Am.* v. *Walsh*, 538 U.S. 644 (2003); *St. Thomas-St. John Hotel & Tourism Ass'n, Inc.* v. *Gov't of U.S. Virgin Islands*, 218 F.3d 232, 241 (3d Cir. 2000); *Farricielli* v. *Holbrook*, 215 F.3d 241, 245 (2d Cir. 2000); *Guar. Nat'l Ins. Co.* v. *Gates*, 916 F.2d 508, 511-512 (9th Cir. 1990).

That widespread understanding of the Court's case law and settled practice make perfect sense in light of the Court's observation, in *Green*, 474 U.S. at

68, that "the availability of prospective relief of the sort awarded in *Ex parte Young* gives life to the Supremacy Clause." In *Green*, the Court went on to explain that "[r]emedies designed to end a continuing violation of federal law are *necessary* to vindicate the federal interest in assuring the supremacy of that law." *Ibid.* (emphasis added). In other words, the Supremacy Clause loses meaning if prospective relief is unavailable to effectuate it. It therefore stands to reason that the cause of action for prospective relief is rooted in the Supremacy Clause itself.

B. The Court Should Reject Petitioners' Efforts To Sow Doubt About, And To Limit, This Important Cause Of Action Based On Inapposite Case Law Involving Either Section 1983 Or Implied Rights Of Action Under Federal Statutes

In an effort to call into question a cause of action that is "well-established" under this Court's cases (HART AND WECHSLER, *supra*, at 807), petitioners advance various arguments. All are meritless.

First, petitioners seize on a single sentence from *Golden State Transit Corp.* v. *City of Los Angeles*, 493 U.S. 103, 107 (1989), where the Court stated that the Supremacy Clause "is not a source of any federal rights" (internal quotation marks omitted). Pet. Br. 35. But that quotation—viewed in context—merely clarifies that the Supremacy Clause does not create federal rights under 42 U.S.C. § 1983. See *Golden State Transit Corp.*, 493 U.S. at 107 (agreeing with the proposition that "the Supremacy Clause, of its own force, does not create rights *enforceable under § 1983*" (footnote omitted, emphasis added)). In any event, the quotation is beside the point. Even if the

Supremacy Clause does not create "rights," it does create a "federal interest in assuring the supremacy of [federal] law." *Green*, 474 U.S. at 68. That interest can be effectively vindicated only through the sort of prospective relief that the Court has consistently made available in cases like this.[3]

Equally unavailing is petitioners' argument that no cause of action should be recognized in this case because the Federal Medicaid Act itself neither contains an implied cause of action nor gives rise to a cause of action under Section 1983. Pet. Br. 22-26. Contrary to petitioners' submission, this Court's preemption decisions cannot be confined to the boundaries of the Court's Section 1983 and implied-cause-of-action jurisprudence.

This Court approaches preemption cases differently from cases involving enforceable "rights" under Section 1983 and implied rights of action under federal statutes. As noted above, instead of applying the frameworks it has developed for analyzing implied statutory causes of action and Section 1983 claims, see *Cort* v. *Ash*, 422 U.S. 66, 78 (1975), *Gonzaga Univ.* v. *Doe*, 536 U.S. 273, 282 (2002), the Court simply proceeds to the merits in preemption cases. See, *e.g.*, *Lorillard Tobacco Co.* v. *Reilly*, 533 U.S. 525, 540 (2001); *Crosby* v. *National Foreign Trade Council*, 530 U.S. 363, 372-73 (2000); *Foster* v. *Love*, 522 U.S. 67, 70-72 (1997); *Gade* v. *Nat'l Solid Wastes Mgmt. Ass'n*, 505 U.S. 88, 96 (1992). Moreover, if the Court *had* applied those tests, in

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[3] While the Supremacy Clause is the most plausible source of the preemption cause of action, other possibilities do exist. For instance, the United States suggests that it may be rooted "in the courts' historical exercise of equitable powers." U.S. Br. 20.

many preemption cases it would have found no cause of action. See David Sloss, *Constitutional Remedies for Statutory Violations*, 89 IOWA L. REV. 355, 391-98 (2004) (demonstrating that the federal statutes at issue in *Lorillard* and *Crosby* did not create express, implied, or Section 1983 causes of action). Nevertheless, the Court routinely decides such cases on the merits, making it clear that the *Cort* and *Gonzaga* tests are simply inapposite.

This approach is entirely justified. The preemption context is different in several crucial respects from the *Cort* and *Gonzaga* contexts, making different treatment not just rational but imperative. For starters, the *Cort* and *Gonzaga* lines of cases concern statutory causes of action (and, typically, efforts to secure retrospective relief in the form of compensatory or punitive damages). In that setting, the Court was understandably deferential to Congress in defining the precise contours of any available remedy. See *Transamerica Mortg. Advisors, Inc.* v. *Lewis*, 444 U.S. 11, 15 (1979) (noting that "[t]he question whether a statute creates a cause of action, either expressly or by implication, is basically a matter of statutory construction"). By contrast, the Supremacy Clause cause of action vindicates the Constitutional interest in the supremacy of federal law in the face of conflicting state action; therefore, it is entirely appropriate for the judiciary to take a more prominent role in fashioning it. See also Santa Rosa Resp. Br. 22-26 (discussing the Court's decisions recognizing claims arising directly under various other provisions of the Constitution without need of statutory authorization).

Moreover, Section 1983 is targeted at a different class of violations and provides a different set of remedies. Unlike the Supremacy Clause cause of action, which is limited to injunctive relief, Section 1983 allows for monetary damages. As a consequence, the former is necessarily targeted at ongoing or recurring violations, while the latter has no such limitation. The two mechanisms, therefore, have quite different functions: The Supremacy Clause cause of action operates to prevent systemic violations of federal law, while Section 1983 redresses individual injuries in appropriate circumstances. See Sloss, *supra*, at 413-15.

Finally, it should be noted that the Court's consistent concern with Congressional intent in the statutory right of action context, see *Cort*, 422 U.S. at 78, *Gonzaga*, 536 U.S. at 280, actually militates *in favor* of the Supremacy Clause cause of action. Because the Court has consistently allowed private parties to sue for injunctive relief against state officers without a finding that the statute contains a cause of action, Congress has had no reason to provide for such lawsuits explicitly. See *American Nat'l Red Cross* v. *S.G.*, 505 U.S. 247, 252, 260 (1992) (Congress is presumptively aware of settled backdrop of existing law). Far from effectuating congressional intent, petitioners' position would frustrate Congress's reliance on this well-established legal regime.

II. THIS COURT'S ESTABLISHED APPROACH FINDS SUPPORT IN THE HISTORY OF THE SUPREMACY CLAUSE AND IS NECESSARY TO EFFECTUATE ITS PURPOSE AND TO BRING ABOUT THE SIGNIFICANT BENEFITS OF THE PREEMPTION DOCTRINE

The Court's recognition of a cause of action for prospective relief under the Supremacy Clause is entirely consistent with the Clause's original meaning. A review of the history surrounding its adoption reveals two crucial principles: (1) the Framers entrusted the enforcement of federal supremacy to the courts; and (2) they regarded the Supremacy Clause as the means of effectively accomplishing that objective. A state of affairs where federal supremacy is flouted without recourse is repugnant to the Supremacy Clause. The cause of action for preemption actions is therefore essential.

A. The Framers Assigned The Principal Responsibility To Enforce Federal Supremacy To The Courts Rather Than To Congress

The Supremacy Clause was intended to address glaring shortcomings in the Articles of Confederation. See *Hughes* v. *Oklahoma*, 441 U.S. 322, 325 (1979) (the Framers believed that "to succeed, the new Union would have to avoid the tendencies toward economic Balkanization that had plagued relations . . . among the States under the Articles of Confederation"). One legal scholar has aptly summarized the shortcomings of the Articles of Confederation:

> In the absence of something like the Supremacy Clause, state courts might have sought to analo-

> gize federal statutes to the laws of a foreign sovereign, which they could ignore under principles of international law. . . . [Moreover,] [t]he Articles had not been ratified by conventions of the people in each state; states had manifested their assent merely by passing ordinary statutes authorizing their delegates to sign the Articles . . . . James Madison fretted that as a result, "whenever a law of a State happens to be repugnant to an act of Congress," it "will be at least questionable" which law should take priority . . . .

Caleb Nelson, *Preemption*, 86 VA. L. REV. 225, 247-48, 251 (2000) (quoting James Madison, *Vices of the Political System of the United States* (Apr. 1787), in 9 PAPERS OF JAMES MADISON 345, 352 (R. Rutland & W. Rachal eds. 1975)).

To address these structural deficiencies in the Articles, the Framers included the Supremacy Clause, which broadly provides that "the Laws of the United States . . . *shall* be the supreme Law of the Land . . . *any Thing in the Constitution or Laws of any State to the Contrary notwithstanding.*" U.S. CONST., art. VI, cl. 2 (emphasis added). By its terms, the Supremacy Clause makes all federal laws automatically preemptive of state and local laws to the extent that the latter impose conflicting obligations or requirements. It declares that federal law "shall" be supreme, not that it "may" displace inconsistent state and local regimes—that is, it states an affirmative constitutional guarantee that federal law will control; it is not a statement that federal law has the mere potential to trump in case of conflict.

That affirmative guarantee reflects a deliberate choice by the Framers. During the Constitutional Convention, the Founders considered "three mechanisms for resolving conflicts between federal and state law." Bradford Clark, *Separation of Powers as a Safeguard of Federalism*, 79 TEX. L. REV. 1321, 1348 (2001). Compare NGA Br. 14-19 (discussing only two of the three mechanisms). Significantly for present purposes, each of the three proposed mechanisms relied on different institutions of government to enforce the principle of federal supremacy, each with markedly different consequences for what the Clause would accomplish in practice.

First, the Virginia (or Large State) Plan proposed "authorizing the Union to use military force to coerce the states to comply with federal law." Bradford Clark, *Unitary Judicial Review*, 72 GEO. WASH. L. REV. 319, 325 (2003). This plan would have placed authority in the hands of the Executive Branch. But "[t]he delegates were immediately opposed to the use of force" and "[t]he Convention tabled the proposal and never seriously entertained this alternative." *Id.* at 325-26 & nn.44-47.

Second, the Virginia Plan alternatively recommended "that the National Legislature ought to be impowered . . . to negative all laws passed by the several States, contravening in the opinion of the National Legislature the articles of Union." Madison, *Notes on the Constitutional Convention* (May 29, 1787), in 1 THE RECORDS OF THE FEDERAL CONVENTION OF 1787, at 21 (Max Farrand, ed. 1911) ("FARRAND'S RECORDS"). Under this "congressional negative" as originally proposed, Congress alone

would have had the power to "negative" all state laws that, in Congress's judgment, violated the federal Constitution. Importantly, the delegates apparently envisioned the congressional negative (by analogy to the Crown's prerogative to approve Colonial laws) as operating to *prevent* state laws from going into effect *until* Congress acted (except in special circumstances). Indeed, James Madison argued that anything other than this powerful congressional negative would be ineffective because it would allow the States to "pass laws which will accomplish their injurious objects before they can be repealed" by Congress or invalidated by the federal courts. 2 FARRAND'S RECORDS 27.

Third, the New Jersey Plan included a resolution that "was in substance and concept, if not in form, similar to the current language of the Supremacy Clause." Viet Dinh, *Reassessing the Law of Preemption*, 88 GEO. L.J. 2085, 2089 (2000). It "would have required state courts (subject to federal appellate review) to enforce the Laws of the United States . . . as 'the supreme law of the respective States.'" Clark, *supra*, 72 GEO. WASH. L. REV. at 327 (quoting 1 FARRAND'S RECORDS 245).

The Convention initially approved the "congressional negative" in its original form. *Id.* at 326. But Charles Pinckney "moved to expand the negative" by giving Congress the power to negate any state law that Congress regarded as "improper" (rather than merely contrary to the federal Constitution). At that point, the small-State delegates strongly objected, and the Convention not only rejected Pinckney's proposal but also "subsequently reconsidered and rejected even the original

congressional negative." *Ibid.* The congressional negative was unacceptable to a majority of States because it "would have allowed *Congress* to determine for itself the scope of its powers vis-à-vis the states." *Ibid.* (emphasis added).

"[T]he Convention subsequently adopted the Clause immediately after rejecting the congressional negative." *Id.* at 327. In so doing, the Convention rejected the arguments of James Madison (who had been the primary drafter of the Virginia Plan) that adoption of the congressional negative was "essential to the efficacy & security of the Genl. Govt." 2 FARRAND'S RECORDS 27. Disagreeing with Madison, Gouverneur Morris explained that any "law that ought to be negatived *will be set aside in the Judiciary departmt.* and if that security should fail; may be repealed by a Nationl. law." *Id.* at 28 (emphasis added). Similarly, Roger Sherman argued that the congressional negative was "unnecessary" because the state courts "would not consider as valid any law contravening the Authority of the Union, and which the legislature would wish to be negatived." *Id.* at 27.

All of this makes clear that the Convention delegates who opposed the congressional negative did so because, among other things, they viewed it as unnecessary once the Supremacy Clause had been included in the Constitution. In other words, the Supremacy Clause was viewed as an *adequate means* of addressing the problem the congressional negative was meant to solve—namely, the possibility that States would flout federal law. See *The Federalist No. 15* (Hamilton) (noting that "*in practice* [the resolutions of the Continental Congress] are mere

recommendations which the States observe or disregard at their option" (emphasis added)). The Supremacy Clause was not understood as a mere aspiration, but rather as an affirmative guarantee that would accomplish this defining objective of the constitutional scheme.

Furthermore, the Supremacy Clause *assigned to the courts* in the first instance the duty to ensure that state laws that were inconsistent with federal laws would be accorded no effect (and thus preempted). Indeed, the specific language of the Supremacy Clause confirms the Framers' intent that it be enforced by the Judiciary. See U.S. CONST., art. VI, cl. 2 ("This Constitution, and the Laws of the United States . . . and all Treaties . . . shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby; any Thing in the Constitution or Laws of any State to the Contrary notwithstanding."). The first clause establishes a hierarchy of federal law and authority; the second is expressly directed at "Judges."

As for the third clause—"any Thing in the Constitution or Laws of any State to the Contrary notwithstanding"—scholarship has established that its form would have been understood by the Framers (and late-Eighteenth-Century judges) as a so-called "*non obstante*" clause. Such clauses were specifically *directed at courts* and understood as a directive concerning the rules of interpretation to apply to federal statutes alleged to conflict with state law. See Nelson, *supra*, 86 VA. L. REV. at 232, 235-44, 291-303. The *non obstante* form of the Supremacy Clause, then, confirms the Framers' plan to vest responsibility for interpreting and enforcing the

Supremacy Clause in the judiciary. *Id.* at 232, 245-64.

In short, the Framers expected the Supremacy Clause to prevent widespread defiance of federal law, and they expected the courts to have primary institutional responsibility for effectuating that result. As respondents demonstrate, this expectation was amply justified by the contemporary practice of suits in equity to restrain officials from unauthorized actions. *Dominguez* Resp. Br. 11-17. In allowing a cause of action for prospective relief on the grounds of preemption, this Court is simply facilitating and performing the role assigned to the judiciary by the Supremacy Clause—namely, preventing systematic violations of federal law by state officials.

While petitioners and their *amici* acknowledge that the Framers vested this responsibility in the judiciary—and specifically rejected the congressional negative proposal—they fail to apprehend the perverse consequence that rejecting a cause of action for preemption would have. In the absence of such a cause of action, asserting federal supremacy *would require congressional action.* As illustrated by this case (and the numerous examples detailed above), there are numerous instances in which federal law conflicts with state law but does not provide a statutory cause of action or an individual "right" within the ambit of 42 U.S.C. § 1983. Petitioners would require Congress to take affirmative action to supply a means to assert federal supremacy, by creating (or, in the case of § 1983, triggering) a cause of action. Petitioners would, in short, require action by the very institution (Congress) that the Framers passed over before the courts could discharge their

assigned duties under the Supremacy Clause. That is exactly backward.[4]

Indeed, many statutes do not expressly provide for a private cause of action, and this Court has been appropriately cautious in finding implied causes of action and allowing statutory claims to be brought under Section 1983. See *Cort*, 422 U.S. at 78; *Gonzaga Univ.*, 536 U.S. at 282. As noted above, these statutory causes of action are necessarily circumscribed by congressional intent. See *Davis* v. *Passman*, 442 U.S. 228, 240-41 (1979) (noting that "it is entirely appropriate" for Congress to determine who may enforce statutes, and drawing a contrast with the Constitution, where "the judiciary is clearly discernible as the primary means" of enforcement). This makes the statutory causes of action poorly suited, however, to vindicate the Constitutional interest in federal supremacy.

B. Petitioners' Rule Would Harm Businesses And Consumers And Undermine The Significant Benefits Flowing From The Preemption Doctrine

Preemption is a pervasive and highly beneficial feature of our system of government. By virtue of the Supremacy Clause and the doctrine of preemption that flows directly from it, state and local governments may not impose requirements that conflict with federal law. Both Congress and regulatory agencies also rely on preemption as a

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[4] Relying on the Executive Branch to enforce the Supremacy Clause (see Pet. Br. 44 n.15) similarly ignores the history of the Supremacy Clause and the institutional choices made by the Framers.

crucial tool in reducing or eliminating the burdens that flow from multifarious (and even conflicting) legal and regulatory requirements imposed by 50 States and thousands of municipal and local governments. In significantly limiting the effectiveness of federal preemption, petitioners' position would undermine three crucial benefits that flow from an effective preemption regime: (1) promotion of regulatory uniformity; (2) promotion of a unified national marketplace for goods and services; and (3) enablement of national deregulatory policies. These benefits reach far beyond the statutory scheme at issue here.

1. *Regulatory uniformity.* Without the protection of preemptive federal laws, companies may be subject to inconsistent and indeed incompatible regulation by thousands of state, municipal, and local entities. Not surprisingly, Congress has repeatedly invoked the benefits of regulatory "uniformity" in enacting preemption provisions in a variety of settings—especially with regard to nationally distributed products. See, *e.g.*, Federal Railroad Safety Act, 49 U.S.C. § 20106(a)(1) ("Laws, regulations, and orders related to railroad safety . . . shall be nationally uniform to the extent practicable.").

The principal advantages flowing from regulatory uniformity are economic efficiencies in the manufacturing and distribution processes. As one commentator has explained in describing the origins of the preemption clause of the Nutrition Labeling and Education Act of 1990, 21 U.S.C. § 343-1, "[p]reparing different labeling, advertising, and food formulations for different states is costly" and "[i]nconsistent labeling laws can slow food manufacturing and

distribution, raise prices, and confuse consumers confronted with different information and warnings." Michele Bradley, *The States' Role in Regulating Food Labeling and Advertising: The Effect of the Nutrition Labeling and Education Act of 1990*, 49 FOOD & DRUG L.J. 649, 653 (1994). Modern manufacturing processes and distribution networks must be altered, and invariably are made less efficient, to account for regulatory variations in the markets for which the products are bound. This is further complicated where the products themselves are mobile and apt to be used in multiple jurisdictions. As a general matter, then, regulatory uniformity has the effect of decreasing the costs of production, distribution, and regulatory compliance, and thus has the potential to lower the price of goods and services for consumers.

2. *Promotion of a unified national market.* In certain cases the costs of complying with a welter of diverse or inconsistent regulatory requirements become so large that manufacturers may elect either not to serve particular markets at all or to "conform" their products "with the most restrictive applicable law." Bradley, 49 FOOD & DRUG L.J. at 654.[5] In the

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[5] Commentators have recognized the possibility of this occurring as a result of modern product liability litigation. Thus, as Professor Michael McConnell has explained: "[S]tate-by-state determination of the law of products liability seems to have created a liability monster. This is because each state can benefit in-state plaintiffs by more generous liability rules, the costs being exported to largely out-of-state defendants; while no state can do much to protect its in-state manufacturers from suits by plaintiffs in the other states. Thus, competition among the states in this arena leads to one-sidedly pro-plaintiff rules of law." Michael McConnell, *Federalism: Evaluating the Founders' Design*, 54 U. CHI. L. REV. 1484, 1499 (1987); see also Michael McConnell, *A Choice-of-Law Approach to Products-Liability*

latter scenario, the net result is that "[s]tate enforcement activities" in several or even in a single jurisdiction can have the extraterritorial effect of "regulat[ing] . . . manufacturers nationally." *Ibid.*

In enacting many preemption clauses, Congress appears to have acted out of a concern over the potential burdens imposed on the national market—and on interstate commerce—by divergent state and local regulations. Thus, Congress has allowed for limited waivers or exemptions from express preemption schemes where state or local laws that do "not unreasonably burden interstate commerce." Federal Railroad Safety Act, 49 U.S.C. § 20106(a)(2)(C); see also Hazardous Materials Transportation Act, 49 U.S.C. § 5125(e)(2); Consumer Product Safety Act, 15 U.S.C. § 2075(c)(2). The desire to protect interstate commerce against disparate state rules also undergirds various preemption clauses enacted by Congress to regulate the channels and instrumentalities of interstate commerce (such as trains, airplanes, trucks, boats, and cars). See, *e.g.*, Safety Appliance Acts, 49 U.S.C. §§ 20301-20306; Locomotive Inspection Act, 49 U.S.C. §§ 20701-20703.

Preemption of divergent and potentially conflicting state and local requirements thus plays an important role in ensuring and protecting the development of a unified national marketplace for goods and services. Indeed, only through preemption by the federal government may the problem of

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Reform, *in* NEW DIRECTIONS IN LIABILITY LAW 90, 92 (Walter Olson ed., 1988) (discussing the reasons why "the cost of a given state's liability laws, as they apply to mass-marketed products, is borne by consumers nationwide").

incompatible state and local commands be effectively addressed and remedied.

3. *Deregulation.* Whenever the federal government wishes to pursue a deregulatory approach to some area of the economy, the federal power to legislate *preemptively* is critically important. Without such authority, a nationwide program of deregulation will fall flat (except in the unlikely event that there is nationwide unanimity). Accordingly, this Court has recognized that "a federal decision to forgo regulation in a given area may imply an authoritative federal determination that the area is best left *un*regulated, and in that event would have as much pre-emptive force as a decision *to* regulate." *Arkansas Electric Coop. Corp.* v. *Arkansas Public Service Comm'n*, 461 U.S. 375, 384 (1983). This Court has applied that principle in various settings. See, *e.g.*, *Ray* v. *Atlantic Richfield Co.*, 435 U.S. 151, 178 (1978) (holding preempted Washington state ban on large oil tankers in Puget Sound).

Moreover, Congress has repeatedly decreed this type of preemption under the federal labor laws. See *NLRB* v. *Nash-Finch Co.*, 404 U.S. 138, 144 (1971) ("For a state to impinge on the area of labor combat designed to be free is quite as much an obstruction of federal policy as if the state were to declare picketing free for purposes or by methods which the federal Act prohibits.") (internal quotation marks omitted); *Bethlehem Steel Co.* v. *New York State Labor Relations Board*, 330 U.S. 767, 774 (1947) (preemption occurs "where failure of the federal officials affirmatively to exercise their full authority takes on the character of a ruling that no such

regulation is appropriate or approved pursuant to the policy of the [federal labor] statute").

Congress has also relied on this rationale in enacting preemption provisions that target certain modes of transportation. For example, the aptly-named Airline Deregulation Act of 1978 (ADA), which regulates air carriers (49 U.S.C. § 41713(b)), preempts state laws that regulate "price[s], route[s], or service." See *Morales* v. *Trans World Airlines*, 504 U.S. 374 (1992). In enacting that statute, "Congress' overarching goal" was to "help[] assure transportation rates, routes and services that reflect 'maximum reliance on competitive market forces,' thereby stimulating 'efficiency, innovation, and low prices,' as well as 'variety' and 'quality.'" *Rowe*, 552 U.S. at 371 (quoting *Morales*, 504 U.S. at 378). Congress has taken similar steps in deregulating the trucking industry. See *id.* at 367-68.

In sum, a well-functioning preemption regime is crucially important to businesses and consumers. By preventing widespread disregard of federal law by state officials, the Supremacy Clause cause of action vindicates the Constitutional interest in federal supremacy while also securing the considerable benefits of uniform regulation, integrated markets, and effective deregulation.

III. PETITIONERS' ATTEMPTS TO NARROW THE CAUSE OF ACTION UNDER THE SUPREMACY CLAUSE TO EXCLUDE THIS CASE IMPROPERLY IMPORT CONCERNS THAT ARE NOT GROUNDED IN THE SUPREMACY CLAUSE, AND ARE APPROPRIATELY ADDRESSED BY STANDING RULES AND THE SUBSTANTIVE LAW OF PREEMPTION

A. The Supremacy Clause Does Not Support Petitioners' Proposed Limitation, And Standing Rules Ensure That Preemption Lawsuits Are Brought, As Here, Only By Appropriate Plaintiffs

Faced with the reality that this Court routinely entertains preemption challenges by private parties, petitioners and the United States struggle to limit this line of authority in a way that would exclude the present case. In addition to relying on inapposite lines of cases involving Section 1983 and statutory rights of action (see pages 13-16, *supra*), they contend that, if the pertinent federal statute does not specifically confer "rights" on private parties, then a cause of action should be allowed only when preemption is used "solely as a defense to state regulation of a defendant's (or putative defendant's) conduct." Pet. Br. 44; see also U.S. Br. 22 (arguing that the challenged regulations "do not regulate respondents' primary conduct"). This restriction is not grounded in the Supremacy Clause, and, in any event, it is both unnecessary and inconsistent with the Court's approach to preemption cases.

For starters, petitioners and the United States provide virtually no support for this "primary

conduct" test, presumably because neither the text nor the purpose of the Supremacy Clause admits of such a limitation. By its terms, the Supremacy Clause makes *all* federal law supreme—there is no suggestion that only "federal affirmative rights" or "federal defenses" have such force. The absence of such a textual distinction is fully consistent with the clause's purpose, which was to guarantee the priority of federal law across the board. See *supra* pp. 17-23. Nothing in the Supremacy Clause itself suggests that federal law only "sometimes" trumps inconsistent state and local regimes.

Underlying petitioners' proposed restriction is the notion that such a test would somehow serve to restrict the cause of action to an appropriate set of plaintiffs. This function, however, is already performed by standing doctrine. See *Indep. Living Ctr. of S. California, Inc.*, 543 F.3d at 1057 (noting that a similar argument made by the district court appeared simply to "reflect traditional standing doctrine"). The three "irreducible constitutional minimum" elements of standing—injury in fact, causation, and redressability—already enforce appropriate limits on those who may assert a constitutional interest in a preemption action. *Steel Co.* v. *Citizens for a Better Env't*, 523 U.S. 83, 102-103 (1998) (internal quotation marks omitted).

In preemption cases, the injury-in-fact and causation requirements ensure that suit can be brought only by plaintiffs who have suffered a concrete injury (such as the reductions in payments suffered by respondents in these cases) that is fairly traceable to the defendants' enforcement of allegedly preempted laws (such as petitioners' enforcement of

California's rate reductions). Importantly, because the Supremacy Clause cause of action is for prospective relief (not retrospective relief such as damages), plaintiffs can demonstrate redressability only if their injury is either ongoing or likely to recur. See *City of Los Angeles* v. *Lyons*, 461 U.S. 95, 105 (1983). This also tends to restrict preemption lawsuits to cases like this one, where the plaintiffs are (or, in the absence of injunctive relief, will be) repeatedly and systematically injured by government action they claim is in violation of federal law.

There is simply no indication that the Court intended to restrict the class of potential preemption plaintiffs any further than this. For example, there is no reason to believe that when *Shaw* speaks of "plaintiff[s] who seek[] injunctive relief from state regulation," it means to import a "primary conduct" restriction that would exclude the respondents here, who will suffer enormous financial losses and may ultimately be forced to limit the availability of crucial health services to beneficiaries. See *Golden State Transit Corp.*, 493 U.S. at 114 (Kennedy, J., dissenting) (explaining that an "*injured party* does not need § 1983 to vest in him a right to assert that an attempted exercise of jurisdiction or control violates the proper distribution of powers within the federal system" (emphasis added)).

This Court's recent decision in *Rowe* is a particularly vivid illustration of the illogic of petitioners' position. The plaintiffs there were transport carrier associations. They argued that two provisions of Maine tobacco law were invalidated by the Federal Aviation Administration Authorization Act of 1994, which preempted state trucking

regulations. 552 U.S. at 367-68. One of these provisions regulated carriers directly, by restricting transport of tobacco into Maine. *Id.* at 369, 372. The Court held that it was preempted. *Id.* at 373. The second provision, however, did not directly regulate trucking; instead, it directed the state's tobacco *retailers* to employ only those delivery services that followed certain provisions. *Id.* at 372. The Court took note of this distinction: "We concede that the regulation here is less 'direct' than it might be, for it tells *shippers* what to choose rather than *carriers* what to do." *Ibid.* The Court went on, however, to explain the distinction was without a difference: "Nonetheless, the effect of the regulation is that carriers will have to offer tobacco delivery services that differ significantly from those that, in the absence of the regulation, the market might dictate. And that being so, treating sales restrictions and purchase restrictions differently for pre-emption purposes would *make no sense*." *Ibid.* (emphasis added, internal quotation marks omitted).

In other words, the direct and indirect regulations were identical for preemption purposes, and there was no reason to treat them differently. But according to the petitioners, courts *must* treat them differently for purposes of defining the preemption *cause of action*. In petitioners' world, the truckers in *Rowe* would have had a cause of action with respect to one provision but not the other, equally preempted provision. That makes no sense: Indirect regulation can be just as injurious to affected parties and just as inimical to federal supremacy as direct regulation. Accordingly, there is no justification for exempting indirect regulation from preemption lawsuits.

B. Whether Spending Clause Legislation Should Be Treated Differently Is A Question Of Preemption Doctrine

Petitioners' final effort at restricting the scope of the Supremacy Clause cause of action is their contention that the cause of action disappears in the Spending Clause context. See Pet. Br. 46. In particular, petitioners maintain that, because Spending Clause legislation resembles a contract, any remedy for noncompliance must be supplied by the "terms of the . . . contract." *Id.* at 47. This argument is confused conceptually and groundless doctrinally. Its most basic defect, however, is that it is totally out of place: It goes to whether there is preemption, not to the existence of a cause of action to enforce the Supremacy Clause.

Conceptually, the contract argument has little to recommend it. "Conditional spending statutes are no less 'law' than any other kind of federal legislation." Samuel Bagenstos, *Spending Clause Litigation in the Roberts Court*, 58 DUKE L.J. 345, 391 (2008). The Supremacy Clause itself certainly contains no exception for laws enacted under the Spending Clause. Even though Spending Clause statutes impose obligations only on States that accept the conditional offer of funds, "that fact does not make their obligations any less binding (or any less a product of 'law') than the obligations imposed by any other federal statute." *Ibid.* This Court's jurisprudence has been entirely consistent with this principle. In particular, this Court has repeatedly held that Spending Clause statutes preempt inconsistent state legislation. See, *e.g.*, *Blum* v. *Bacon*, 457 U.S. 132, 138 (1982); *Carleson* v.

Remillard, 406 U.S. 598, 604 (1972). That is precisely what petitioners claim cannot happen. Pet Br. 47-48.

Moreover, while petitioners style this argument as a question of whether the preemption cause of action is available with respect to Spending Clause statutes, really their argument is that Spending Clause statutes are not preemptive. Indeed, petitioners give the game away right off the bat by arguing that "[p]rinciples of supremacy, *and of preemption generally*, have no application to allegations that a state has failed to satisfy a federal funding condition." Pet. Br. 46 (emphasis added); see also U.S. Br. 21 (claiming that respondents use the term preemption "in a rather special sense" (internal quotation marks omitted)). Whether or not preemption principles suggest that Spending Clause statutes should be treated differently is simply a question of the substantive law of preemption, to be resolved on the merits. In other words, petitioners' argument goes to the existence and extent of an actual conflict between federal and state law sufficient to trigger preemption. But the Supremacy Clause cause of action does not leap in and out of existence depending on whether the preemption claim is ultimately successful—the existence of a cause of action is logically antecedent to and conceptually distinct from the merits. Nor does the cause of action switch on and off depending on the Constitutional provision under which the relevant federal statute was enacted. If a statute is not preemptive, the courts can and will make that determination (by contrast, in this case, courts have definitively ruled that the relevant state and federal laws *do* stand in conflict). There is no reason to

anticipate that scenario by creating carve-outs in the Supremacy Clause cause of action.

Notably, this was precisely the approach taken by seven Members of the Court in *Pharm. Research & Mfrs. of Am.* v. *Walsh*, 538 U.S. 644 (2003). Although seven Justices split 4-3 over the question of whether the Medicaid Act preempted Maine's rebate program, *id.* at 661-668, 669-74, 682-90, all seven recognized that this was properly a preemption issue—none questioned the availability of the private cause of action. There is no reason for the Court to adopt any other approach to this case.

CONCLUSION

The judgment of the Ninth Circuit should be affirmed.

Respectfully submitted.

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TOBY DOUGLAS,
Director, California Department of Health Services,
Petitioner,
v.
INDEPENDENT LIVING CENTER
OF SOUTHERN CALIFORNIA, INC., *et al.*, *Respondents*.

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SANTA ROSA MEMORIAL HOSPITAL, *et al.*, *Respondents*.

On Writs of Certiorari to the United States Court of Appeals for the Ninth Circuit

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BRIEF OF FORMER HHS OFFICIALS AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS

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congressional intent and would interfere with the Secretary's discretion to administer the Medicaid program. *See* Brief for the United States as Amicus Curiae Supporting Petitioner, *Douglas* v. *Indep. Living Ctr. of S. Cal., Inc.*, No. 09-958 (U.S. filed May 26, 2011) [hereinafter "Gov't Br."].

As *amici* explain below, HHS has never embraced such a view of private enforcement. To the contrary, it has consistently been HHS's position that private enforcement of § 30(A) is not just appropriate, but also necessary to ensure that states comply with this critical regulatory mandate. Nor is there anything to the Justice Department's suggestion that private enforcement would interfere with the Secretary's discretion. As a matter of both historical practice and current law, private enforcement only complements the Secretary's authority.

SUMMARY OF ARGUMENT

Since its inception in 1965, the central purpose of the Medicaid program has been to provide access to "mainstream" health care for those who cannot afford to purchase private medical services. To that end, of

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> A State plan for medical assistance must . . . provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area . . . .

42 U.S.C. § 1396a(a)(30)(A).

the almost 100 procedural and substantive requirements that the Medicaid Act imposes on state plans, perhaps none is more vital than the "equal access" mandate presently codified in § 30(A), which has its roots in a 1966 HEW Handbook delineating requirements for state Medicaid plans, and a regulation (45 C.F.R. § 250.30(a)(5)) first promulgated by HEW in 1971. *See DeGregorio* v. *O'Bannon*, 500 F. Supp. 541, 549 & n.13 (E.D. Pa. 1980). And as § 30(A)'s legislative history makes clear, the equal access provision exists to ensure that providers will not refuse to treat Medicaid beneficiaries due to inadequate state reimbursement rates. *See, e.g.*, H.R. REP. NO. 101-247, at 390 (1989), *reprinted in* 1989 U.S.C.C.A.N. 2060, 2116. After all, without meaningful enforcement of the equal access provision, states would have little incentive to reimburse providers at mainstream rates, and providers would in turn have little incentive to treat Medicaid beneficiaries.

Despite its agreement with these basic principles, the Justice Department's *amicus* brief maintains that private enforcement of the equal access provision is inconsistent with the statutory scheme, implicitly suggesting that Congress intended for the provision to be enforced exclusively by HHS. *See, e.g.*, Gov't Br., *supra*, at 12. But exclusive administrative enforcement of § 30(A) is logistically, practically, legally, and politically unfeasible. First, because the Medicaid Act contemplated—and has historically been understood to allow—direct redress by beneficiaries, neither CMS nor HHS has the resources to provide comprehensive oversight of state-by-state compliance with the equal access provision. Second, because funds for the

administration of Medicaid are provided by appropriation, they are subject to far greater congressional budget constraints than Medicaid benefits. Third, as CMS itself has repeatedly conceded, it is limited both practically and legally in its authority to both enforce § 30(A) and provide remedies for violations thereof. Fourth, and finally, even in the absence of such constraints, the "cooperative federalism" behind Medicaid means that the Executive Branch is under far more political pressure from states than from private parties.

None of these points are unique to the equal access mandate—or to the Medicaid Act more generally. But taken together, they reinforce the general proposition that the federal government lacks the financial, legal, logistical, and political wherewithal comprehensively to enforce § 30(A) against the states. Thus, whereas the Department of Justice suggests that "Recognition of a nonstatutory cause of action for Medicaid providers and beneficiaries in this setting would be in tension with the nature of the federal-state relationship and the enforcement scheme contemplated by the statute," Gov't Br., *supra*, at 25, the reality is that *exclusive* federal enforcement would be in far greater tension with the scheme Congress intended and HHS has historically supported and embraced, if for no other reason than that it would not—and probably cannot—produce meaningful compliance with the Medicaid Act's access mandate.

In the alternative, the Justice Department's *amicus* brief suggests that private enforcement of the equal access provision would interfere with the Secretary's discretion in administering the Medicaid program. *See* Gov't Br., *supra*, at 32. The federal

government has never previously opposed private enforcement of the equal access provision on the ground that it would interfere with the Secretary's authority to administer the Medicaid program. In cases in which § 30(A) is ambiguous, the Secretary's reasonable interpretation thereof will generally be entitled to *Chevron* deference. *See, e.g.*, *Pharm. Research & Mfrs. of Am.* v. *Thompson*, 362 F.3d 817, 821–22 (D.C. Cir. 2004). As a result, she would not be bound by prior judicial decisions holding that particular state plan amendments do or do not violate § 30(A) in cases in which the statute is held to be ambiguous. *See Nat'l Cable & Telecomms. Ass'n* v. *Brand X Internet Servs.*, 545 U.S. 967, 982 (2005).

Moreover, a judicial decision upholding or invalidating a state plan amendment based upon an interpretation of ambiguous language within § 30(A) would not preclude the state from submitting either that amendment or a revised one to the Secretary for approval. *See, e.g.*, *New York* v. *Shalala*, 119 F.3d 175, 180–81 (2d Cir. 1997). Private enforcement therefore provides a means for meaningful statutory enforcement both until and unless the Secretary has the opportunity to exercise her discretion, and to ensure that the Secretary is acting within her discretion. Ultimately, then, private enforcement may even expand the Secretary's discretion by providing a means of ensuring state compliance with the equal access mandate that is far less draconian than the specific remedies directly available to the Secretary. This understanding has been the cornerstone of HHS policy throughout the history of the Medicaid Act, and remains the prevailing view of those charged with administering the program.

ARGUMENT

I. THE MEDICAID PROGRAM DEPENDS UPON THE ENFORCEABILITY OF § 30(A)

a. The Central Purpose of Medicaid is To Provide Access to "Mainstream" Health Care for Those Who Cannot Afford Private Medical Services

In the Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286, Congress created the Medicare and Medicaid programs with the express goal of providing "mainstream" health care services for those individuals unlikely to have access to such services on the private market—including children, the elderly, those with certain disabilities, and the poor. *See, e.g.*, *Medicare and Medicaid*, Hearings Before the S. Comm. on Finance, 91st Cong., 2d Sess., pt. I, at 57 (1970) (statement of Hon. John G. Veneman, Under-Secretary, Department of Health, Education, and Welfare); *see also* 42 C.F.R. § 430.0 (2011) (describing purpose of the Medicaid program).

Medicaid was specifically designed to eliminate—or at least ameliorate—the "dual-track" system then in effect, pursuant to which those of means received medical care from private physicians, whereas those who could not afford such treatment received care in ambulatory clinics and emergency rooms, if at all. *See* PAUL STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 151–52 (1982); Sidney D. Watson, *Medicaid Physician Participation: Patients, Poverty, and Physician Self-Interest*, 21 AM. J.L. & MED. 191, 192–93 (1995). Thus, it is no overstatement to suggest that meaningful access to mainstream medical services is the linchpin of the Medicaid regime.

Congress sought to effectuate this access goal by authorizing open-ended federal grants to states subject to a series of complex and interlocking procedural and substantive conditions. In short, states that choose to participate (as all have)[4] must submit a detailed "plan for medical assistance" that comprehensively outlines the nature and scope of the state's Medicaid program. If that plan is approved, the state becomes entitled under the Medicaid Act to "reimbursement" of a substantial percentage of its outlays (the "FFP," or federal financial participation), which varies based on state economic circumstances between the statutory floor (50%) and ceiling (83%). *See* 42 U.S.C. § 1396d(b); 42 C.F.R. § 433.10(b) (2011). *See generally Wilder* v. *Va. Hosp. Ass'n*, 496 U.S. 498, 502 (1990) (describing the structure of the Medicaid program).

As a result of this statutory structure, the Secretary of HHS has two direct means of ensuring state compliance with the Medicaid Act's procedural and substantive requirements: She must decline to approve state plans (or amendments thereto) ex ante, including amendments that change reimbursement policies, if they fail to comport with the Act or with regulations promulgated under it. *See* 42 U.S.C. §§ 1396a(b), 1396c; 42 C.F.R. § 430.15. And even if the plan or the relevant amendment thereto has been approved, she may also initiate an ex post "compliance" proceeding pursuant to 42 U.S.C. § 1316(a) if the state plan either on its face or as applied no longer complies with the Act. The

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4. Including the District of Columbia, American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands, there are 56 different jurisdictions currently participating in the Medicaid program.

compliance proceeding in turn could produce termination of FFP either for entire categories of state assistance, or, in the extreme, for the entire state Medicaid program. *See* 42 U.S.C. § 1396c; 42 C.F.R. § 430.35.

b. Section 30(A) Exists To Ensure that Providers Will Not Refuse To Treat Medicaid Beneficiaries Due To Inadequate Reimbursement Rates

Of the almost 100 procedural and substantive requirements that the Medicaid Act imposes on state plans, perhaps none is more central to Medicaid's access-oriented goal than the "equal access" mandate presently codified in § 30(A).[5] Although the equal access language did not appear in the original text of the Medicaid Act, Congress did initially require state Medicaid plans to "provide that the medical assistance made available to individuals receiving aid or assistance under any such State plan . . . shall not be less in amount, duration, or scope than the medical or remedial care or services made available to individuals not receiving aid or assistance under any such plan." Social Security Amendments of 1965, § 121(a), 79 Stat. at 345 (formerly codified at 42 U.S.C. § 1396a(a)(10)(A)(ii)).

To that end, since immediately after the enactment of the Medicaid Act, HEW (and later

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5. Even the CMS website provides in the first sentence of its "Overview" of state plan reimbursement that "CMS reviews State plan amendment reimbursement methodologies for services provided under the State plan for consistency with Section 1902(a)(30)(A) of the Social Security Act (the Act) and *other* applicable federal statutes and regulations." Medicaid Reimbursement & Finance, CMS.gov, http://www.cms.gov/MedicaidRF/ (emphasis added).

HHS) interpreted the statute to require that states maintain adequate reimbursement levels for covered services. *See* 42 C.F.R. § 447.204 (2011) ("The agency's payments must be sufficient to enlist enough providers so that services under the plan are available to recipients at least to the extent that those services are available to the general population."). While § 447.204 itself was not promulgated until 1978, its roots date back to a 1966 HEW Handbook delineating requirements for state Medicaid plans, and to a regulation (45 C.F.R. § 250.30(a)(5)) first promulgated in 1971. *See DeGregorio* v. *O'Bannon*, 500 F. Supp. 541, 549 & n.13 (E.D. Pa. 1980) (tracing this evolution); *see also* Medicaid Regulations, 43 FED. REG. 45,176, 45,258 (Sept. 29, 1978).

Nevertheless, worried that the regulatory equal access mandate was being under-enforced, Congress in 1989 went one step further, formally codifying the equal access language in § 30(A) as part of the Omnibus Budget Reconciliation Act of 1989, Pub. L. No. 101-239, § 6402(a), 103 Stat. 2106, 2260. As the authoritative House Budget Committee Report accompanying the Act noted,

> The Committee recognizes that payment levels are only one determinant of physician participation [in Medicaid]. However, the Committee believes that, without adequate payment levels, it is simply unrealistic to expect physicians to participate in the program . . . .

H.R. REP. NO. 101-247, at 390 (1989), *reprinted in* 1989 U.S.C.C.A.N. 2060, 2116. *See generally Ark. Med. Soc'y, Inc.* v. *Reynolds*, 6 F.3d 519, 526 (8th Cir.

1993) (discussing the purpose and significance of the 1989 amendment to § 30(A)).

Congress in 1989 thereby made explicit what HEW and HHS had assumed since 1966: to vindicate its central goal, the Medicaid program requires that states reimburse providers at reasonable rates—not because beneficiaries should be entitled to dollar-for-dollar parity in the funding of their health care, but because they are entitled by statute to equal access to *providers*, virtually none of whom would participate in Medicaid if they would only be reimbursed at inadequate levels. *See* Abigail R. Moncrieff, Comment, *Payments to Medicaid Doctors: Interpreting the "Equal Access" Provision*, 73 U. CHI. L. REV. 673, 686 (2006) [hereinafter "Moncrieff, *Interpreting the "Equal Access" Provision*"].

Indeed, the 1989 amendment to § 30(A) was prompted by the jointly shared sentiment expressed by the National Governors Association, Congress, and HHS that the Medicaid Act had not yet succeeded in eliminating the "dual-track" system that had prompted the program in the first place. *See* H.R. REP. NO. 101-247, at 390, *reprinted in* 1989 U.S.C.C.A.N. at 2116; *see also Medicare and Medicaid Initiatives*, Hearings before the Subcomm. on Health and the Envt. of the House Comm. on Energy and Commerce, 101st Cong, 1st Sess. 108 (1989) (statement of Richard N. Jensen, National Governors' Association).

Inasmuch as one could offer a comparable critique today, *see, e.g.*, Denise Grady, *Children on Medicaid Shown To Wait Longer for Care*, N.Y. TIMES, June 15, 2011, at A24 (citing Joanna Bisgaier & Karrin V. Rhodes, *Auditing Access to Specialty Care for Children With Public Insurance*, 364 NEW ENG. J.

MED. 2324 (2011)), two points nevertheless bear mention: First, the 1989 amendment *has* helped. *See, e.g.*, Watson, *supra*, at 200 (noting a fifteen-percent increase in state reimbursement rates for physicians in the first few years after the amendment).

Second, and in any event, Congress in 1989 underscored the extent to which the central purpose of the Medicaid program would be jeopardized without equal access, since states would otherwise have little incentive to set reimbursement rates at market levels, and providers, in turn, would have little incentive to offer services at the resulting reimbursement rates. *See* Moncrieff, *Interpreting the Equal Access Provision*, *supra*, at 686 ("Although it would be controversial to claim that § 30(A) requires rate parity, the provision's legislative history indicates that Congress intended to require a closer relationship between Medicaid rates and private-market rates than existed in 1989." (footnote omitted)).

To that end, the goal of the 1989 amendment was not merely to codify the equal access mandate in the abstract, but, in the process, to make it more likely that the mandate would be meaningfully enforced. As Secretary Shalala testified before the House Commerce Committee in 1996, "[i]mplicit in the concept of defined populations and defined benefits is the notion of a meaningful enforcement mechanism." *Hearing on the Unanimous Bipartisan National Governors Association Agreement on Medicaid*, Hearing Before the House Comm. on Commerce, 104th Cong., 2d Sess. (1996) (statement of Hon. Donna E. Shalala) [hereinafter "*NGA Agreement* Hearing"].

II. EXCLUSIVE ENFORCEMENT OF § 30(A) BY HHS IS LOGISTICALLY, PRACTICALLY, LEGALLY, AND POLITICALLY UNFEASIBLE

In its *amicus* brief in support of the Petitioner, the Justice Department does not dispute any of the above. Nor does it question the signal importance of the equal access mandate to the Medicaid program more generally. *See, e.g.*, Gov't Br., *supra*, at 12 ("It is essential under [§ 30(A)] that States carefully consider what impact payment rate changes may have on the availability of providers sufficient to furnish covered care and services to Medicaid beneficiaries.").

What the brief neglects, though, is both the well-established history of the Medicaid Act (within which private enforcement has figured prominently in ensuring adherence to the equal access mandate), and the extent to which that history has influenced the federal government's direct enforcement ability. And notwithstanding that this history has been given short shrift by lower-court decisions concerning the private enforceability of § 30(A) after *Gonzaga University* v. *Doe*, 536 U.S. 273 (2002), *see, e.g.*, *Equal Access for El Paso* v. *Hawkins*, 509 F.3d 697 (5th Cir. 2007), the fact remains that both the history and present structure of the Medicaid program stand in marked contrast to the arguments offered by the Justice Department in this case.

a. Private Enforcement of § 30(A) Is Wholly Consistent With the Structure and History of the Medicaid Act

Under the Medicaid Act as initially enacted, there was no question that the statute contemplated tandem enforcement of the Act's central procedural

and substantive requirements by the Secretary and by private plaintiffs—including providers and beneficiaries. As testament to that understanding, dozens of suits were brought during the first 15 years under the Medicaid program in which private litigants sought to enforce those provisions requiring states to reimburse providers on a "reasonable cost related basis," such as § 13(B) (as amended in 1972).[6]

Section 30(A) itself was not originally subject to private enforcement, but that was because at the time, it imposed a ceiling on reimbursement rates, and not a floor, *see, e.g.*, *Opelika Nursing Home, Inc.* v. *Richardson*, 323 F. Supp. 1206, 1210–11 (M.D. Ala. 1971), and not because private enforcement was in any way disfavored. To the contrary, suits in which beneficiaries and providers sought to enforce the floor imposed by the "reasonable cost" provisions were legion, *see Wilder*, 496 U.S. at 516 & n.14 (noting examples), even as searching federal review of state plans expanded. Thus, "it is clear that prior to the passage of the Boren Amendment, Congress intended that health care providers be able to sue in federal court for injunctive relief to ensure that they were reimbursed according to reasonable rates." *Id.* at 516. And as the *Wilder* Court emphasized, HEW policy throughout the 1970s reflected (and supported) this view of the availability and utility of concurrent

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6. For exemplar cases, see *Cal. Hosp. Ass'n* v. *Obledo*, 602 F.2d 1357, 1358 (9th Cir. 1979); *Minn. Ass'n of Health Care Facilities, Inc.* v. *Minn. Dept. of Pub. Welfare*, 602 F.2d 150, 152 (8th Cir. 1979); *Hosp. Ass'n of N.Y. State, Inc.* v. *Toia*, 577 F.2d 790, 792 (2d Cir. 1978); *Mass. Gen. Hosp.* v. *Weiner*, 569 F.2d 1156, 1157 (1st Cir. 1978); *St. Mary's Hosp. of E. St. Louis, Inc.* v. *Ogilvie*, 496 F.2d 1324, 1326–28 (7th Cir. 1974); and *Catholic Med. Ctr. of Brooklyn & Queens, Inc.* v. *Rockefeller*, 430 F.2d 1297, 1298 (2d Cir. 1970).

enforcement. *See id.* at 518 n.15 (citing legislative testimony and other official agency statements).

Largely in response to the increase in both private litigation and federal administrative oversight, Congress altered the status quo in 1980 by enacting the Boren Amendment, Omnibus Budget Reconciliation Act of 1980, Pub. L. No. 96-499, § 962(a), 94 Stat. 2599, 2650–51 (formerly codified at 42 U.S.C. § 1396a(a)(13)).[7] The Boren Amendment, along with additional provisions enacted in 1981, rewrote § 13 of the Medicaid Act with the general goal of providing greater flexibility to the states to set payments for inpatient services. *See* H.R. REP. NO. 97-158, at 293 (1981). *See generally* Malcolm J. Harkins III, *Be Careful What You Ask For: The*

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7. In pertinent part, the Boren Amendment rewrote § 13(A) to provide that:

> [A] State plan for medical assistance must . . . provide . . . for payment . . . of the hospital services, nursing facility services, and services in an intermediate care facility for the mentally retarded . . . through the use of rates (determined in accordance with the methods and standards developed by the State . . .) *which the State finds, and makes assurances satisfactory to the Secretary*, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access (taking into account geographic location and reasonable travel time) to inpatient hospital services of adequate quality . . . .

42 U.S.C. § 1396a(a)(13)(A) (1981) (emphasis added).

Repeal of the Boren Amendment and Continuing Federal Responsibility To Assure that State Medicaid Programs Pay for Cost Effective Quality Nursing Facility Care, 4 J. HEALTH CARE L. & POL'Y 159, 168–78 (2001) (summarizing the Boren Amendment's origins and legislative history).

At its core, the Boren Amendment "transferred to the states the primary authority and responsibility, previously exercised by [HHS] for determining and assuring that Medicaid payment rates complied with the substantive standards of the Medicaid Act." Harkins, *supra*, at 159. And yet, although Congress thereby intended to minimize the federal government's role in ensuring that state plans complied with certain aspects of the Medicaid Act, the legislative history was just as clear that Congress meant for private judicial enforcement to remain as the backstop. As the House Budget Committee concluded, "Of course, in instances where the States or the Secretary fail to observe these statutory requirements, the courts would be expected to take appropriate remedial action." H.R. REP. NO. 97-158, at 301; *see also* Edward Alan Miller, *Federal Administrative and Judicial Oversight of Medicaid: Policy Legacies and Tandem Institutions Under the Boren Amendment*, 38 PUBLIUS 315, 321–26 (2008) (summarizing the widespread private judicial enforcement of the Boren Amendment and its effects).

This Court relied on that understanding in *Wilder*, which held that the language of the Boren Amendment and its history manifested a clear congressional intent to create a substantive federal right privately enforceable by health care providers via 42 U.S.C. § 1983. *See* 496 U.S. at 512–20.

Although *Wilder* concerned only § 13 of the Medicaid Act, the Court's analysis is telling here for two distinct—but related—reasons. First, the Court reaffirmed the relationship between private suits and state adherence to the Medicaid Act's substantive standards. *See, e.g., id.* at 515 ("In passing the Boren Amendment, Congress sought to decentralize the method for determining rates, but not to eliminate a State's fundamental obligation to pay reasonable rates."). Second, because the "equal access" language codified in 1989 was designed with the Boren Amendment very much in mind, courts viewed the private enforceability of § 30(A) as following from *Wilder*'s analysis of § 13. *See, e.g., Orthopaedic Hosp.* v *Belshe*, 103 F.3d 1491, 1498–99 (9th Cir. 1997); *Ark. Med. Soc'y*, 6 F.3d at 525–28; *see also Ill. Hosp. Ass'n* v. *Edgar*, 765 F. Supp. 1343, 1349 (N.D. Ill. 1991) ("Section 1396a(a)(30) appears to complement the Boren Amendment . . . .").

Wilder's reading of the Boren Amendment thereby reinforced what had consistently been HHS's position: whatever degree of oversight the Secretary was supposed to exercise over state plans, private enforcement remained the safety valve for ensuring state adherence to the rate minima within the Medicaid Act, including the "equal access" language in § 30(A). *See, e.g.*, United States' Brief as *Amicus Curiae* at 8, *Exeter Mem. Hosp. Ass'n* v. *Belshe*, 943 F. Supp. 1239 (E.D. Cal. 1996) (No. 96-693) [hereinafter *"Exeter* Amicus Br."] ("Under [*Wilder*] and its progeny, a State that implements a pending [plan amendment] assumes the risk that, in addition to actions that HCFA may take, providers may bring suit challenging the State's payment rates or seeking to enjoin the State's implementation of the

[amendment] for failure to comply with the substantive or procedural requirements of the statute and regulations." (citation omitted)).

To be sure, when Congress repealed the Boren Amendment in the Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4711, 111 Stat. 251, 507–08, some of the legislative history reflected hostility to such private enforcement. *See, e.g.*, H.R. REP. NO. 105-149, at 591 (1997) ("It is the Committee's intention that, following enactment of this Act, neither this nor any other provision of [§ 1396] will be interpreted as establishing a cause of action for *hospitals and nursing facilities* relative to the adequacy of the rates they receive." (emphasis added)).

But even if this legislative history could govern given the absence of statutory text to that effect, *see, e.g.*, *In re NYASHA Litig.*, 318 F. Supp. 2d 30, 32 (N.D.N.Y. 2004) (noting that § 30(A) "was not affected by repeal of the Boren Amendment"), *aff'd*, 444 F.3d 147 (2d Cir. 2006) (per curiam), Congress nevertheless left intact private suits by *other* providers (the Medicaid Act identifies almost two dozen classes of eligible providers besides nursing homes and hospitals), and, more fundamentally, by beneficiaries. To that end, pre-*Gonzaga* case law barring providers from enforcing § 30(A) via § 1983 turned on the assumption that beneficiaries could still sue after the repeal of the Boren Amendment—indeed, that the availability of beneficiary suits rendered provider suits superfluous. *See, e.g.*, *Pa. Pharmacists Ass'n* v. *Houstoun*, 283 F.3d 531, 543–44 (3d Cir. 2002) (en banc) (Alito, J.) ("Not only is HHS responsible for ensuring that state plans are administered in accordance with these requirements,

but Medicaid recipients plainly satisfy the intended-to-benefit requirement and are thus potential private plaintiffs." (citation omitted)); *see also Evergreen Presbyterian Ministries Inc.* v. *Hood*, 235 F.3d 908, 928–29 & n.26 (5th Cir. 2000).

HHS took a similar view at the time, *see, e.g.*, *Medicaid and Welfare Reform*, Hearing Before the S. Comm. on Finance, 104th Cong., 2d Sess. (1996) (statement of Hon. Donna E. Shalala) (suggesting that repealing the Boren Amendment "resolves states' concern about their exposure to providers' suits in Federal court, and does not undermine beneficiaries' ability to enforce their Federal guarantee to coverage and benefits"),[8] and has continued to adhere thereto, *see, e.g.*, Brief for Respondents at 36, *Alaska Dep't of Health & Soc. Servs.* v. *CMS*, 424 F.3d 931 (9th Cir. 2005) (No. 04-74204) (advancing CMS's position that the repeal of the Boren Amendment did not affect the meaning or enforceability of § 30(A)).

b. As a Result, Neither CMS Nor HHS Has the Resources To Provide

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8. In addition to Secretary Shalala's testimony, HCFA in 1999 proposed a new rule that would have based plan amendment approval "on simple assurances that a public process had been used when adopting reimbursement policy changes," Miller, *supra*, at 328, all-but conceding that private litigation—rather than rigorous administrative oversight—had become the principal means for enforcing § 30(A). *See* 64 FED. REG. 54,263 (Oct. 6, 1999); *see also* Miller, *supra*, at 328 (citing a 1997 letter by Sally Richardson, HCFA's Director of the Center for Medicaid and State Operations, for the proposition that "HCFA sought to minimize its role in reviewing state plan amendments governing reimbursement beyond even the minimal standards established by Boren," resulting in that much more of a focus on private enforcement).

Comprehensive Oversight of State-by-State Compliance With § 30(A)

Although the above history demonstrates the extent to which both Congress and HHS have always viewed private enforcement (by beneficiaries, at a minimum) as key to the Medicaid regime, the history matters for a separate, but equally important, reason: *Because* private enforcement was historically available under the Medicaid Act, HHS was never faced with the specter of exclusive enforcement authority, and could instead rely on the availability of private enforcement to supplement—if not supplant—its own responsibilities. Thus, fewer than 500 federal employees are today tasked with supervising 56 different Medicaid programs administering nearly $400 billion in federal funds every year. Out of necessity, most of those employees are concerned with bookkeeping and routine financial management of Medicaid funds at the state level, and not with reviewing state plans and plan amendments for compliance with § 30(A).

Indeed, as Professor Moncrieff has explained, partly *because* private enforcement was routinely available (and championed by HEW and HHS), the government has itself never aggressively sought to enforce the equal access mandate, or to obtain the necessary financial and administrative resources to do so. Instead,

> CMS tends to rubber-stamp state plans and to pass the buck to state agencies when providers and beneficiaries complain. In fact, CMS directs more of its Medicaid resources to policing individual providers' compliance with Medicaid fraud and abuse laws than

> policing state agencies' compliance with the federal statute. On the occasions that CMS does reject state plans or insist on amendments thereto, it almost always does so to protect its own funds from perceived state raids.

Abigail R. Moncrieff, *The Supreme Court's Assault on Litigation: Why (and How) It Might Be Good for Health Law*, 90 B.U. L. REV. 2323, 2340–41 (2010) [hereinafter "Moncrieff, *Assault on Litigation*"] (footnotes omitted); *see also* Nicole Huberfeld, *Bizarre Love Triangle: The Spending Clause, Section 1983, and Medicaid Entitlements*, 42 U.C. DAVIS L. REV. 413, 466 (2008) (documenting CMS's focus on fraud prevention in lieu of access enforcement).[9]

Even a proposed new CMS rule interpreting § 30(A) recognizes the inability of CMS to provide for comprehensive enforcement. Thus, the new rule would require states to conduct their *own* periodic "access reviews," and to submit the results of such reviews "prior to submission of a [plan amendment] to reduce rates or alter the structure of provider payment rates in circumstances that could result in access issues for a covered service." Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 76 FED. REG. 26,342, 26,345 (May 6, 2011). Moreover, the new rule would allow states

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9. In addition, "CMS has never developed a robust administrative remedy for individuals wanting to challenge CMS approval of Medicaid plans. Although some administrative processes exist for raising challenges to Medicaid plans, including challenges to reimbursement rates, Medicaid's administrative process (unlike Medicare's) has never been an effective means of enforcing the federal statute." Moncrieff, *Assault on Litigation*, *supra*, at 2341 (footnotes omitted).

to avoid compliance actions by developing their own "corrective action plans" when access issues are identified, which CMS "would not treat . . . as a finding of non-compliance, but as evidence of a good faith effort by the State to remain in compliance." *Id.* at 26,347. If CMS had the resources to provide for such oversight at the federal level, the provision of such fox-guarding-the-henhouse incentives to states to self-monitor would hardly be necessary.

c. Because Funds for the Administration of Medicaid are Provided by Appropriation, They Are Subject to Far Greater Congressional Budget Constraints

Even if CMS preferred to prioritize federal enforcement of the equal access mandate, it would encounter the additional hurdle that its enforcement budget—unlike the reimbursements that comprise FFP—must be appropriated on an annual basis. Under current budgetary rules, the administrative expenses of Medicare and Medicaid, like some but not all federal social insurance programs, are classified as "discretionary" spending, in contrast to funding of Medicaid *services*, which is classified as "mandatory" spending.

As a result, CMS must request funds annually to administer Medicaid, competing with the National Institutes of Health, the Food and Drug Administration, the Centers for Disease Control, and other HHS agencies that typically are far more popular subjects of legislative munificence. Thus, according to CMS's own certified report, the funds available for federal administration of Medicaid during the most recent fiscal year totaled roughly $141 million (less than $2.10 per beneficiary),

whereas total program outlays totaled $382 billion. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., CMS FINANCIAL REPORT: FISCAL YEAR 2010, at 8, 52 (2011), https://www.cms.gov/CFOReport/Downloads/2010_CMS_Financial_Report.pdf. In other words, administrative expenses represented less than four-hundredths of one percent of total program costs.

As the CMS reports indicate, for most of the last two decades, program outlays have grown at a proportionately—as well as absolutely—higher rate than administrative budgets.[10] Thus, even if CMS made increased administrative enforcement of § 30(A) (to say nothing of the rest of the Medicaid Act) a priority, the reality of the current budget deficit renders it unlikely that the agency would be able to expand its enforcement ability.

d. CMS is Limited Both Practically and Legally in its Authority To Enforce § 30(A) and To Provide Remedies for Violations Thereof

At a more fundamental level, though, the principal obstacle to meaningful federal enforcement of the equal access mandate is neither logistical nor financial, but practical. As is true of any federal grant-in-aid program, "the posture of the federal agency toward its grantees is not generally that of a referee calling fouls, but that of a coach giving support in the form of cash and expertise." Edward A. Tomlinson & Jerry L. Mashaw, *The Enforcement*

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10. Over the last three years alone, expenditures for Medicaid administration *declined* by 44%, from $253 million for FY2008. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., CMS FINANCIAL REPORT: FISCAL YEAR 2008, at 46 (2009), https://www.cms.gov/CFOReport/Downloads/2008_CMS_Financial_Report.pdf.

of Federal Standards in Grant-in-Aid Programs: Suggestions for Beneficiary Involvement, 58 VA. L. REV. 600, 620 (1972).

Medicaid is hardly unique in this regard, but "[t]his general reluctance by federal agencies to police states by withholding program funding is particularly acute in the Medicaid context, where massive budget overruns in state programs are almost a matter of course and states are politically 'locked-in' to [FFP]." Brian J. Dunne, Comment, *Enforcement of the Medicaid Act Under 42 USC § 1983 After* Gonzaga University v Doe: *The "Dispassionate Lens" Examined*, 74 U. CHI. L. REV. 991, 994–95 (2007); *cf. Arthur C. Logan Mem. Hosp.* v. *Toia*, 441 F. Supp. 26, 27 (S.D.N.Y. 1977) ("The Secretary can withhold payment or he can negotiate with a State. He cannot compel compliance.").

Further to that end, HHS itself has been quite candid about its unwillingness to pursue the more drastic legal remedies with which Congress has provided it:

> A compliance action, which results in the withholding of FFP, has a potentially detrimental effect on Medicaid recipients and providers. If HCFA were to withhold FFP pursuant to a compliance action, recipients may well be deprived of medical assistance because the State may no longer be able to provide certain services. Particularly where a pending [plan amendment] involves the expansion of Medicaid services, a compliance action can deprive recipients of those expanded services. Thus, before exercising its

> discretionary authority to initiate a formal compliance action against a State, HCFA carefully weighs the advantages and disadvantages.

Exeter Amicus Br., *supra*, at 13 n.11.

Also relevant is CMS's disinclination to initiate compliance actions *while* state plan amendments are pending. *See, e.g.*, *id.* at 11 ("HCFA does not generally initiate a compliance action against a State that implements a [plan amendment] prior to HCFA approval during the period that the agency is reviewing the [amendment], whether before or following a request for additional information."). Given the agency's limited litigation resources, it has long adhered to the "general rule" that it "does not generally expand the resources necessary to pursue a compliance action against a State where HCFA might ultimately approve the [plan amendment] at issue." *Id.* at 12.

Taken together with the extensive administrative and judicial review that findings of non-compliance and denials of plan amendments both typically precipitate,[11] the practical result is that there is almost always a substantial period of time during which HHS can take no administrative action to

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11. After either a denial of a proposed plan amendment or an administrative finding of non-compliance, the state has a statutory right to a full administrative hearing, the final decision in which may in turn be reviewed by the relevant U.S. Court of Appeals pursuant to the Administrative Procedure Act. *See* 42 U.S.C. §§ 1316(a), 1396c. For exemplar cases, see *Iowa Dep't of Hum. Servs.* v. *CMS*, 576 F.3d 885 (8th Cir. 2009); *Md. Dep't of Health & Mental Hygiene* v. *CMS*, 542 F.3d 424 (4th Cir. 2008); *Minnesota* v. *CMS*, 495 F.3d 991 (8th Cir. 2007); and *La. Dep't of Health & Hosps.* v. *CMS*, 346 F.3d 571 (5th Cir. 2003).

remedy an ongoing violation of § 30(A). *See, e.g.*, Statement of Interest of the United States at 1–3, *Planned Parenthood of Ind., Inc.* v. *Comm'r of the Ind. State Dep't of Pub. Health*, No. 11-cv-630 (S.D. Ind. June 16, 2011) [hereinafter "*Planned Parenthood* Amicus Br."] (explaining why injunctive relief is both necessary and appropriate to prevent a state from continuing to violate the Medicaid Act until HHS has the opportunity formally to reject a plan amendment).

Not surprisingly, then, "HHS has long recognized that access issues are not easily resolved in formal or adjudicatory settings." Brief of Amicus Curiae Secretary of Health & Human Services at 12, *Clark* v. *Kizer*, 758 F. Supp. 572 (E.D. Cal. 1990) (No. 87-1700). Instead, "HHS regional officials have sought to monitor and promote access through informal processes, principally by raising the issue of the adequacy of rates in meetings and correspondence with state authorities." *Id.* The proposed new CMS rule reflects this approach, since it aims to create new means of promoting adherence to § 30(A) short of federal disapproval or compliance proceedings. *See* 76 FED. REG. at 26,345.

Finally, it bears noting that there is no realistic financial incentive for CMS aggressively to enforce § 30(A)—quite to the contrary. Because FFP is a function of the funds the state *actually* expends reimbursing providers, state non-compliance with § 30(A) necessarily results in lower reimbursement rates, thereby saving the federal government money. *See* Moncrieff, *Assault on Litigation*, *supra*, at 2341 ("In that framework, CMS is unlikely to enforce something like the Equal Access Provision, which would, in its violation, save federal money."). If

anything, because poorer states tend to have the highest percentage of their Medicaid outlays reimbursed by the federal government, the states under the greatest pressure to cut costs will be those in which the federal government spends (and stands comparatively to save) the highest proportion of funds.

e. Even in the Absence of Such Constraints, the "Cooperative Federalism" Behind Medicaid Means That the Executive Branch is Under Far More Political Pressure from States than From Beneficiaries or Providers

Aside from the specific logistical and practical hurdles that CMS would face if it sought aggressively to enforce the equal access mandate, political considerations also suggest that exclusive federal enforcement is unlikely to vindicate the Medicaid Act's access-oriented goal. Under the Medicaid Act, the only permissible way to reduce reimbursements across the board is to tighten eligibility requirements—a measure that itself requires the permission of the federal government. *See* 42 U.S.C. § 1315(a); Judith M. Rosenberg & David T. Zaring, Recent Development, *Managing Medicaid Waivers: Section 1115 and State Health Care Reform*, 32 HARV. J. ON LEGIS. 545 (1995).

As news reports suggest, Arizona and New Jersey have recently made such requests based on current economic conditions, and similar efforts from other states are likely in the offing. *See* Michael A. Fletcher, *GOP Governors Push Back Against Obama on Federal Medicaid Rules*, WASH. POST, June 15, 2011, at A1. And whatever else may be true about

the politically partisan nature of many of these bilateral state-federal negotiations, *see, e.g.*, *id.*, what cannot be gainsaid is that neither providers nor Medicaid beneficiaries have a seat at the table in these discussions, or any means of legally contesting arrangements that are reached therein.

Again, this reality is hardly specific to the Medicaid program. The intended beneficiaries of federal funds are usually underrepresented when it comes to federal-state interactions with regard to program administration. *See generally* Jerry L. Mashaw & Dylan S. Calsyn, *Block Grants, Entitlements, and Federalism: A Conceptual Map of Contested Terrain*, 14 YALE L. & POL'Y REV. 297 (1996). But given that Medicaid consumed nearly 22 percent of all state budgets (including FFP) in FY2010, and as much as 37 percent of some, *see* Fletcher, *supra*, there is every reason to believe that the political pressure the federal government receives from the states will be at its zenith in the Medicaid context, all the more so in light of the absence of comparable pressure to enforce zealously those statutory mandates that compel states (and the federal government) to spend *more* money.

* * *

On their own, none of the above points are unique to the equal access mandate—or to the Medicaid Act more generally. But taken together, they reinforce the general proposition that the federal government lacks the financial, legal, logistical, and political wherewithal comprehensively to enforce § 30(A) against the states. Thus, whereas the Department of Justice suggests that "Recognition of a nonstatutory cause of action for Medicaid providers and beneficiaries in this setting would be in tension with

the nature of the federal-state relationship and the enforcement scheme contemplated by the statute," Gov't Br., *supra*, at 25, the reality is that *exclusive* federal enforcement would be in far greater tension with the scheme Congress intended and HHS has historically supported and embraced, if for no other reason than that it would not—and probably cannot—produce meaningful compliance with the Medicaid Act's access mandate.

III. PRIVATE ENFORCEMENT OF § 30(A) DOES NOT MATERIALLY INTERFERE WITH THE SECRETARY'S DISCRETION

Separate from the contention that private enforcement would generally be inconsistent with the statutory scheme Congress intended to create in the Medicaid Act, the Justice Department's brief concludes by offering the related but distinct argument that private enforcement of § 30(A) would interfere with the Secretary's authority to administer the Medicaid Act, and, specifically, to approve or reject state plans and amendments thereto. *See, e.g.*, Gov't Br., *supra*, at 32 ("Recognition of a nonstatutory private right of action would mean that multiple federal courts across different jurisdictions would similarly (and perhaps simultaneously) be called on to decide such compliance questions."); *see also id.* ("[T]he proceedings would inevitably lead to the development and application of different legal standards.").

Even if this concern was well-founded (and, as explained below, it is not), the fact remains that private enforcement has been a prominent feature of the Medicaid Act in general, and the equal access provision in particular, since well before this Court's 2002 decision in *Gonzaga University* v. *Doe*, 536 U.S.

275. And in the nine years since *Gonzaga*, neither Congress nor HHS has taken any steps to alter the tandem enforcement structure that emerged during the first 37 years of the program. Thus, it is no surprise that, whatever other critiques such private enforcement may have engendered, the Justice Department can point to no prior instance in which interference with the agency's discretion was invoked to militate against private remedies.

a. The Federal Government Has Never Previously Opposed Private Enforcement of § 30(A) on the Ground That It Would Interfere With the Secretary's Authority

Although it has consistently been HHS's position that private enforcement serves an important role in vindicating the Medicaid Act's central goals, the same view was not always shared by the Justice Department—even prior to this litigation. In *Wilder*, for example, the government's brief as *amicus curiae* (which was not joined by any HHS officials) argued against allowing for private enforcement of the Boren Amendment via 42 U.S.C. § 1983, offering much of the same analysis concerning the nature of the statutory scheme that the *Wilder* Court ultimately rejected (and that the Justice Department's brief in this case largely reprises). *See* Brief for the United States as Amicus Curiae Supporting Petitioners, *Wilder*, 496 U.S. 498 (No. 88-2043).

Tellingly, though, the *Wilder* brief did not suggest that private enforcement of the Boren Amendment would interfere with the *Secretary*'s discretion. Instead, it argued that

> Congress did not intend to confer on Medicaid providers an "enforceable

> right" to challenge state reimbursement decisions in federal court. Lawsuits like respondent's interfere with *state* autonomy and discretion, and they contravene Congress's intent that the degree of federal oversight be minimized. There is no reason to believe that Congress wished the participating States to absorb the substantial costs entailed by such litigation.

Id. at 23 (emphasis added).

Indeed, testifying before the House Commerce Committee in 1996, Secretary Shalala specifically suggested that, rather than interfering with the agency, "[r]eview by federal courts . . . *promotes* efficiency," because it allows for those with principal responsibility for the content of federal law to control its application across multiple jurisdictions, especially "when Medicaid interacts, as is often the case, with other federal statutes (such as Medicare, Social Security, SSI and AFDC)." *NGA Agreement* Hearing, *supra* (statement of Hon. Donna E. Shalala) (emphasis added). These disparate examples reflect the same broader truth, *i.e.*, that the federal government has never previously argued against private enforcement of the Medicaid Act on the ground that such suits would interfere with the Secretary's discretion in administering the statute.

b. Unless Private Enforcement Yields an Unambiguous Construction of § 30(A), the Secretary Retains Discretion Over State Plans

The absence of prior examples, and the thrust of Secretary Shalala's testimony, may perhaps be attributed to the fact that it is difficult to understand

how private enforcement *could* meaningfully interfere with the Secretary's authority. In that regard, the Justice Department's analysis of the potential for interference if the decision below were affirmed appears to neglect settled principles of administrative law.

First, as a general matter, if § 30(A) is ever ambiguous as to what constitutes "equal access," *see, e.g.*, *Alaska Dep't of Health & Soc. Servs.* v. *CMS*, 424 F.3d 931, 935 (9th Cir. 2005), the Secretary's reasonable interpretation of that language will be entitled to *Chevron* deference, *see, e.g.*, *Pharm. Research & Mfrs. of Am.* v. *Thompson*, 362 F.3d 817, 821–22 (D.C. Cir. 2004) ("In the case of the Medicaid payment statute, the Congress expressly conferred on the Secretary authority to review and approve state Medicaid plans as a condition to disbursing federal Medicaid payments. . . . Congress [thereby] manifested its intent that the Secretary's determinations, based on interpretation of the relevant statutory provisions, should have the force of law." (quoting *United States* v. *Mead Corp.*, 533 U.S. 218, 229 (2001)); *see also West Virginia* v. *Thompson*, 475 F.3d 204, 212-13 (4th Cir. 2007) (holding that *Chevron* deference applies to CMS's interpretation of Medicaid Act provision in approval of state plan amendments); *Harris* v. *Olszewski*, 442 F.3d 456, 466–67 (6th Cir. 2006) (same); *S.D. ex rel. Dickson* v. *Hood*, 391 F.3d 581, 595–96 (5th Cir. 2004) (same). *See generally Thomas Jefferson Univ.* v. *Shalala*, 512 U.S. 504, 512 (1994).

Second, because the Secretary's reasonable interpretations of § 30(A) will generally receive *Chevron* deference, she is not bound by prior judicial decisions holding that particular state plan

amendments do or do not violate § 30(A) in cases in which the statute is held to be ambiguous. As this Court has explained, "A court's prior judicial construction of a statute trumps an agency construction otherwise entitled to *Chevron* deference only if the prior court decision holds that its construction follows from the unambiguous terms of the statute and thus leaves no room for agency discretion." *Nat'l Cable & Telecomms. Ass'n* v. *Brand X Internet Servs.*, 545 U.S. 967, 982 (2005); *see also id.* at 982–83 ("Only a judicial precedent holding that the statute unambiguously forecloses the agency's interpretation, and therefore contains no gap for the agency to fill, displaces a conflicting agency construction."). Even if a case arose in which a court construed § 30(A) to be unambiguous, that would only prove the point, for the Secretary at that point would have *no* statutory discretion to approve or reject the state plan amendment there at issue. *See, e.g.*, *Ark. Med. Soc'y*, 6 F.3d at 526 n.5 ("[T]he operative effect of [§ 30(A)] is to underscore the mandatory nature of the state plan requirements by expressly prohibiting the Secretary's discretion to approve funds for state provisions that do not conform to federal law.").

Third, and related, a judicial decision upholding or invalidating a state plan amendment based upon an interpretation of ambiguous language within § 30(A) would not preclude the state from submitting either that amendment or a revised one to the Secretary for approval. *See, e.g.*, *New York* v. *Shalala*, 119 F.3d 175, 180–81 (2d Cir. 1997). Of course, such a possibility does not mean that private enforcement would be meaningless; the effect of the court's decision in such a case would be, critically, to

bar enforcement of the challenged amendment until and unless it is approved by the Secretary. *See, e.g.*, *Exeter* Amicus Br., *supra*, at 7–10 (setting forth as HCFA's position that states assume the risk of private litigation if they implement a plan or plan amendment prior to agency approval). So understood, it is difficult to see how private enforcement could jeopardize the Secretary's discretion before that discretion could even be exercised.

The upshot of these points is that private judicial enforcement of § 30(A) cannot meaningfully interfere with the Secretary's discretion to interpret § 30(A) in approving or rejecting state plan amendments. Where a state plan amendment satisfies or violates the plain text of § 30(A), the Secretary possesses no such discretion. And where the statute *is* ambiguous, the Secretary's reasonable interpretation of whether a state plan amendment complies with § 30(A) will necessarily override any prior judicial interpretation—and control any subsequent judicial consideration—of the same amendment. All that private enforcement adds is the ability (which may well be vital from the beneficiaries' perspective) to enjoin a violation of § 30(A) until and unless the Secretary has the opportunity to act.

c. Private Enforcement Provides a Means for Meaningful Statutory Enforcement Both Until and Unless the Secretary Has the Opportunity To Exercise Her Discretion—and to Ensure that the Secretary is Acting Within Her Discretion

Lest the above discussion suggest that private enforcement is but a temporary stop-gap to preserve the status quo until the agency has the chance

formally to approve or reject a state plan or plan amendment, private enforcement also fills the vital gap that the difficulties identified in Part II, *supra*, would otherwise create: As HHS explained in its amicus brief in the *Exeter* litigation, "even if HCFA decides, in the exercise of its discretion, not to bring a compliance action against a State for implementing a [plan amendment] prior to HCFA approval, . . . the State may still be subject to a suit for injunctive and declaratory relief . . . ." *Exeter* Amicus Br., *supra*, at 10; *see also Planned Parenthood* Amicus Br., *supra* (explaining why injunctive relief prior to HHS rejection of a state plan is both necessary and appropriate).

In other words, in addition to not interfering with the Secretary's discretion, private enforcement may even expand the Secretary's discretion by providing a means of ensuring state compliance with § 30(A) that is far less draconian than the administrative remedies directly available to the Secretary. This understanding has been the cornerstone of HHS policy throughout the history of the Medicaid Act, and the prevailing view of those charged with administering the program. Moreover, the Justice Department's present views to the contrary, such a view is completely consistent with the cause of action recognized by the Court of Appeals. *See Indep. Living Ctr. of S. Cal., Inc.* v. *Shewry*, 543 F.3d 1050 (9th Cir. 2008), *cert. granted sub nom. Maxwell-Jolly* v. *Indep. Living Ctr. of S. Cal., Inc.*, 131 S. Ct. 992 (2011).

CONCLUSION

For the foregoing reasons, *amici* respectfully submit that the decisions below be affirmed.

Respectfully submitted,

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AUGUST 5, 2011

APPENDIX

List of *Amici Curiae* Former HHS Officials

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General Counsel, HHS (1979–81)

HON. JOSEPH A. CALIFANO, JR.
Secretary, U.S. Department of Health, Education, and Welfare (1977–79)

PETER B. EDELMAN
Counselor to the Secretary, HHS (1993–95);
Assistant Secretary for Planning and Evaluation, HHS (1995–96)

JUDITH M. FEDER
Principal Deputy Assistant Secretary for Planning and Evaluation, HHS (1993–95)

NAN D. HUNTER
Deputy General Counsel, HHS (1993–96)

RENÉE M. LANDERS
Acting Deputy General Counsel, HHS (1996);
Deputy General Counsel, HHS (1996–1997)

KAREN POLLITZ
Deputy Assistant Secretary for Health Legislation, HHS (1993–97);
Director, Office of Consumer Support, Center for Consumer Information and Insurance Oversight, CMS (2010–11)

HARRIET S. RABB
General Counsel, HHS (1993–2001)

DAVID SATCHER, M.D., PH.D.
U.S. Surgeon General (1998–2002);
Assistant Secretary for Health (1998–2001)

HON. DONNA E. SHALALA
Secretary, HHS (1993–2001)

BRUCE C. VLADECK
Administrator, HCFA (1993–97)

TIMOTHY M. WESTMORELAND
Director of Center for Medicaid and State
Operations, HCFA (1999–2001)

RECORD
AND
BRIEFS

Nos. 09-958, 09-1158, and 10-283

IN THE
Supreme Court of the United States

AUG 4 - 2011
OFFICE OF THE CLERK

TOBY DOUGLAS, Director of the Department of Health Care Services, State of California,
Petitioner,
v.
INDEPENDENT LIVING CENTER OF SOUTHERN CALIFORNIA, INC., A Nonprofit Corporation,

TOBY DOUGLAS, Director of the Department of Health Care Services, State of California,
Petitioner,
v.
CALIFORNIA PHARMACISTS ASSOCIATION, et al.,

TOBY DOUGLAS, Director of the Department of Health Care Services, State of California,
Petitioner,
v.
SANTA ROSA MEMORIAL HOSPITAL, et al.,

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF OF MEMBERS OF CONGRESS AS *AMICI CURIAE* IN SUPPORT OF RESPONDENTS

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INTEREST OF *AMICI CURIAE*

Amici, Representative Henry A. Waxman, Senator Max Baucus, House Minority Leader Nancy Pelosi, Senate Majority Leader Harry Reid, Representative George Miller, Senator Tom Harkin, and Representative Sander M. Levin, are a group of current Members of Congress who support private rights of action for equitable relief in this context.[1] The personal experiences of *amici*, as Members of Congress who have worked extensively on legislation and oversight of Federal health programs, including those authorized under Titles XVIII (Medicare) and XIX (Medicaid) of the Social Security Act, provide insight into Congress' intent to preserve prospective relief to vindicate the supremacy of the Medicaid Act over contrary state legislation. *Amici* are uniquely situated to do so.

Amici support the argument of Respondents that Congress intended to preserve the private cause of action for equitable relief to vindicate the supremacy of Medicaid conditions over contrary state action. *Amici* explain that Congress relied on this Court's longstanding practice of hearing these causes of action, except where statutes expressly barred them. In contrast, the approach suggested by California and the Solicitor General would upend centuries of settled understanding and would undermine the

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[1] No person or entity other than *amici* and their counsel made a monetary contribution to the preparation or submission of this brief. Counsel of record for the parties have consented to the filing of this brief, and letter of consent have been filed with the clerk.

effectiveness of Medicaid. *Amici* believe that such suits are critical here to protect the intended beneficiaries of Medicaid – the Medicaid recipients. Allowing for prospective relief in this narrow context supplements the agency's limited enforcement resources, and can be a more effective measure than using administrative means to cut off federal funding to the program. Because Section 30A is no different than any of the dozens of other Congressional enactments that this Court has allowed to be enforced through the Supremacy Clause, the judgment below should be affirmed.

SUMMARY OF ARGUMENT

Nearly 75 years ago Justice Cardozo set forth the basic principle that when "[federal] money is spent to promote the general welfare, the concept of welfare or the opposite is shaped by Congress, not the states." *Helvering v. Davis*, 301 U.S. 619, 645 (1937). This case implicates not only that venerable principle, but one of even older vintage: the right to seek equitable relief under the Supremacy Clause against state law that is inconsistent with Congressional enactments.

In the posture this case comes to the Court, it is undisputed that California has not complied with its obligations to fund the Medicaid program that Congress enacted and that California agreed to administer. It is equally undisputed that for nearly 200 years, this Court has heard claims under the Supremacy Clause seeking prospective relief based on preemption of inconsistent state law without ever

requiring an express cause of action from Congress to do so.

Now California, joined by the Solicitor General, asks this Court to hold for the first time that Section 30A is not enforceable in a private suit seeking equitable relief. This Court should reject that position for four reasons.

First, Congress has relied on this Court's unbroken practice of permitting suits for equitable relief under the Supremacy Clause. Congress is fully capable of stating when it does not want to allow a private cause of action. And it is fully capable of stating when it does not want an enactment to be construed as displacing state law. But when Congress does not so state, it has long understood that an action for equitable relief will be available to individuals harmed by state law that is inconsistent with federal law. California's broad argument that such relief is available only when Congress has provided an express cause of action is irreconcilable with the many cases from this Court allowing such relief without ever requiring the plaintiff to identify a right of action. And it is also irreconcilable with this Court's practice of presuming that equitable relief is available under *Ex parte Young* unless Congress affirmatively indicates otherwise. *See infra* Part I.

Second, the efforts of California and the Solicitor General to distinguish Section 30A on the ground that it imposes obligations under the Spending Clause are unavailing. This Court has routinely allowed Supremacy Clause actions to enforce

obligations incurred under the Spending Clause. Indeed, this Court not long ago affirmed the availability of that very relief in a case in which the plaintiffs argued that state regulation was preempted by Medicaid. *See PhRMA v. Walsh*, 538 U.S. 644, 662-74 (2003). But more than that, the Spending Clause context provides greater reason, not less, to allow preemption actions. California and the Solicitor General assert that the proper remedy here is for the United States to cut off funding to a state that does not comply with its Medicaid obligations. But that would only dramatically exacerbate the problems of Medicaid recipients in California. In contrast, allowing private attorneys general to supplement the agency's enforcement powers provides a remedy that is consistent with Congress's goals and vindicates the supremacy of federal law. *See infra* Part II.A &B.

Third, California and the Solicitor General are wrong when they contend that a preemption claim is improper here because Respondents are seeking a benefit rather than invoking an immunity. When a state receives federal funds, Congress is equally concerned that a state comply with *all* the conditions attached to those funds, whether they be a limitation on how a state may regulate, or an obligation to provide a certain standard of benefits. *See infra* Part II.C.

Fourth, the argument that there is no right to enforce Section 30A under the Supremacy Clause is particularly weak because Congress has repeatedly debated whether to eliminate Section 30A and/or bar private rights of action, and it has consistently

refused to do so, even as it has eliminated other rights-giving provisions in Medicaid. *See infra* Part III. Congress has expressly chosen to maintain Section 30A knowing full well that it provides enforceable rights. This Court should not override that decision, particularly when doing so would require overturning two centuries of case law.

ARGUMENT

I. CONGRESS HAS RELIED ON THIS COURT'S LONG TRADITION OF ALLOWING PRIVATE SUITS FOR EQUITABLE RELIEF UNDER THE SUPREMACY CLAUSE.

When Congress legislates, it does so with an understanding of the legal principles that will govern the interpretation of what it enacts. *Amici* can attest to the truth of that statement based on their extensive legislative experience. And it is correct as well as a matter of law under this Court's well-settled doctrines. *See, e.g., South Dakota v. Yankton Sioux Tribe*, 522 U.S. 329, 351 (1998) ("We assume that Congress is aware of existing law when it passes legislation.") (quoting *Miles v. Apex Marine Corp.*, 498 U.S. 19, 32, (1990)). For example, when Congress uses terms drawn from the common law, this Court understands that usage indicates Congress's intent to incorporate the terms' common law gloss. *E.g. Scheidler v. Nat'l Org. for Women, Inc.*, 537 U.S. 393, 402 (2003). Likewise, when Congress chooses *not* to amend a statute in the face of a judicial construction, it can be presumed to have acceded to the interpretation this Court articulated.

E.g., *Microsoft Corp. v. i4i Ltd. P'ship*, 131 S. Ct. 2238, 2252 (2011).

The question in this case is whether Congress intended to allow suits under the Supremacy Clause to remedy state law inconsistent with the obligations imposed by Section 30A of the Medicaid Act. And for 200 years this Court's decisions have indicated that such relief is available to vindicate the supremacy of federal law in the absence of an express provision to the contrary. The line of authority establishing this proposition encompasses some of this Court's most seminal cases, both longstanding and of more recent vintage, concerning the preeminence of federal authority. *See, e.g.*, *State v. Wilson*, 11 U.S. (7 Cranch) 164, 166 (1812) (suit initially brought in state court challenging state tax as unconstitutional under Contracts Clause); *Osborn v. Bank of the United States*, 22 U.S. (9 Wheat.) 738 (1824) (suit to enjoin state tax as unconstitutional under Congress's Article I power to constitute Bank of United States); *City of Walla Walla v. Walla Walla Water Co.*, 172 U.S. 1 (1898) (finding tax unconstitutional after considering only whether the Court had jurisdiction); *Fla. Lime & Avocado Growers, Inc. v. Paul*, 373 U.S. 132 (1963) (exercising jurisdiction over private party claim that California statute was preempted by federal regulation); *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96 n.14 (1983) (enjoining state law preempted by ERISA); *Crosby v. Nat'l Foreign Trade Council*, 530 U.S. 363, 366 (2000) (enjoining state law restricting purchases from Burma on preemption grounds).

Congress's understanding that equitable relief is available under the Supremacy Clause has been bolstered by the consistent (until now) position taken by the Executive Branch on this issue. Although the Solicitor General now contends that it is unclear "if ... a private party can bring a federal nonstatutory cause of action for equitable relief ... on preemption grounds," SG Br. at 16, the Executive has routinely appeared in such cases in favor of federal preemption, seeking the benefit of these private suits to vindicate the supremacy of federal law. *See, e.g.*, Brief for the United States as *Amicus Curiae*, *Crosby v. Nat'l Foreign Trade Council*, 530 U.S. 363 (2000) (No. 99-474), 2000 WL 194805; Brief for the United States as Amicus Curiae, *District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125 (1992) (No. 91-1326), 1992 WL 12012049 (filing on behalf of private plaintiffs seeking declaratory judgment that state law is preempted by ERISA).

Indeed, even when the Solicitor General has argued that the state law was not preempted by federal law – thus arguing against private plaintiffs' interest – the Executive never suggested the plaintiffs' lack of a cause of action. *See, e.g.*, Brief for the United States as *Amicus Curiae*, *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316 (1997) (No. 95-789), 1996 WL 340772 (arguing against federal preemption where plaintiffs sought declaratory judgment that ERISA preempted state enforcement action, but failing to raise cause of action question); Brief for the United States as *Amicus Curiae*, *Carleson v. Remillard*, 406 U.S. 598 (1971) (No. 70-250), 1971 WL 133367

(opposing private plaintiffs on Social Security Act preemption of state welfare regulation, but not addressing cause of action); Brief for the United States as *Amicus Curiae*, *Cal. Dep't of Human Res. Dev. v. Java*, 402 U.S. 121 (1971) (No. 70-507), 1971 WL 147066 (same).

Put simply, Congress is fully capable of saying when it does *not* wish to provide a cause of action to individuals. *See, e.g.*, 6 U.S.C. § 134 ("Nothing in this part may be construed to create a private right of action . . . ."). Congress is also fully capable of stating when federal law is *not* intended to preempt state regulation. *See, e.g.*, 29 U.S.C. § 1144(b)(2)(A) ("[N]othing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance . . . ."). But when Congress imposes obligations that do not contain limiting language of that sort, it relies on this Court's venerable practice of permitting suits to enjoin state laws that are preempted by federal law.

Against this background, it is thus remarkable that California's lead argument is that Section 30A's absence of an express right of action signifies that Congress "intended" to foreclose relief under the Supremacy Clause. Pet'r Br. 20-33. This Court has *never* required an express cause of action in its Supremacy Clause cases. To the contrary, this Court has remained steadfastly open to suits for purely prospective relief as a critical but limited safeguard, even while becoming more guarded against suits that seek monetary relief. For example, since this Court held in *Cort v. Ash*, 422 U.S. 66 (1975), that it would apply a more stringent test for implying rights of

action in federal statutes, there have been no fewer than nine cases in which this Court has upheld injunctive relief under the Supremacy Clause.[2] *See, e.g., Lorillard Tobacco Co. v. Reilly*, 533 U.S. 525 (2001); *Crosby v. Nat'l Foreign Trade Council*, 530 U.S. 363 (2000); *Barnett Bank of Marion Cnty., N.A. v. Nelson*, 517 U.S. 25 (1996); *Gade v. Nat'l Solid Wastes Mgmt. Ass'n*, 505 U.S. 88 (1992); *Memphis Bank & Trust Co. v. Garner*, 459 U.S. 392 (1983); *Ariz. Pub. Serv. Co. v. Snead*, 441 U.S. 141 (1979); *Ray v. Atl. Richfield Co.*, 435 U.S. 151 (1978); *Douglas v. Seacoast Prods., Inc.*, 431 U.S. 265 (1977); *Jones v. Rath Packing Co.*, 430 U.S. 519 (1977); *see also Golden State Transit Corp. v. City of Los Angeles*, 493 U.S. 103, 119 (1989) (even where Section 1983 relief is unavailable, "plaintiffs may vindicate [their] pre-emption claims by seeking declaratory and equitable relief in federal district courts through their powers under federal jurisdictional statutes") (Kennedy, J., dissenting).

Instead, a comparison to the *Ex parte Young* doctrine is highly pertinent. *See Ex parte Young*,

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[2] During that period there were also at least seven such cases in which this Court found that injunctive relief was unwarranted. *See, e.g., Ite.' Containers Int'l Corp. v. Huddleston*, 507 U.S. 60 (1993); *Northwest Cent. Pipeline Corp. v. State Corp. Comm'n of Kan.*, 489 U.S. 493 (1989); *Puerto Rico Dep't of Consumer Affairs v. Isla Petroleum Corp.*, 485 U.S. 495 (1988); *Cal. Fed. Sav. & Loan Ass'n v. Guerra*, 479 U.S. 272 (1987); *Malone v. White Motor Corp.*, 435 U.S. 497 (1978); *Ohio Bureau of Empl. Servs. v. Hodory*, 431 U.S. 471 (1977); *United States v. County of Fresno*, 429 U.S. 452 (1977). In not one of those cases did the Court express doubt about the existence of a cause of action in the first place.

209 U.S. 123 (1908). Far from requiring an express authorization to pursue injunctive relief under *Ex parte Young*, this Court *presumes* that Congress intends such relief to be available absent a clear indication by Congress to the contrary. *E.g., Verizon Md., Inc. v. Pub. Serv. Comm'n of Md.*, 535 U.S. 635, 647 (2002) (allowing plaintiff to pursue relief under *Ex parte Young* because statute did not "display any intent to foreclose" that relief).

California and the Solicitor General apparently recognize this anomaly, and indeed the Solicitor General concedes in a footnote late in its brief that it "is not suggesting that Congress has 'displayed an intent not to provide the more complete and more immediate relief that would otherwise be available under *Ex parte Young*.'" SG Br. 32 n.12 (quoting *Verizon*, 535 U.S. at 647) (internal quotation marks omitted). Despite this concession, the Solicitor General appears to contend *Ex parte Young* is not relevant here because "[s]ome have described *Young*" as permitting only a "defens[ive]" action to prevent a state from bringing its own punitive action against the *Young* plaintiff. SG Br. at 19. *Accord* Pet'r Br. at 41. But *Ex parte Young* is not so limited. Such suits may be brought to compel state action required by federal law, and not just to enjoin punitive action. In the highly analogous case of *Edelman v. Jordan*, for example, this Court explained that *Ex parte Young* could be used to compel state officials to comply with the federal time limits for processing and paying applicants for a federal-state aid program on a prospective basis. 415 U.S. 651, 655-56, 664-66 & n.11 (1974). The availability of injunctive relief

was presumed there, even though the Court made no mention of any private right of action. The same result should hold here.

Accordingly, because this Court has never required an express cause of action to seek preemption under the Supremacy Clause, and indeed has consistently presumed that such relief would always be available under *Ex parte Young*, this Court should not disrupt Congress's expectations by ruling that Section 30A does not permit private enforcement under Supremacy Clause just because Congress did not provide an express right of action to do so.

II. THAT SECTION 30A'S OBLIGATIONS ARISE UNDER THE SPENDING CLAUSE MAKES THEM MORE, NOT LESS, SUITABLE FOR ENFORCEMENT UNDER THE SUPREMACY CLAUSE.

California and the Solicitor General contend that because Section 30A's obligations arise under Congress's Spending Clause authority they are inappropriate for enforcement through the Supremacy Clause. From *amici*'s perspective, that conclusion does not follow. When a state or local entity agrees to accept federal funds, it is obligated to use those funds in the manner required by Congress and to comply with any and all conditions put on the funds. As we explain, allowing such suits both comports with this Court's past practice and with common sense.

A. This Court Has Consistently Permitted Preemption Claims Seeking To Enforce Obligations Incurred Under The Spending Clause.

At the outset, it is important to recognize that notwithstanding the assertions of California and the Solicitor General, this Court has never treated Spending Clause obligations differently in allowing claims to proceed under the Supremacy Clause. When Congress exercises its Spending Clause powers, inconsistent state law must give way under the Supremacy Clause, just as it must to any other enactment of Congress. *See, e.g.*, *Lawrence Cnty. v. Lead-Deadwood Sch. Dist. No. 40-1*, 469 U.S. 256, 258 (1985) (holding that the Payment in Lieu of Taxes Act preempted state rules mandating how local governments used the moneys); *Blum v. Bacon*, 457 U.S. 132, 138 (1982) (holding that federal regulations pursuant to the Emergency Assistance Program, which is federally funded under the Social Security Act, preempted state provisions regarding emergency assistance).

Indeed, this Court has heard numerous preemption challenges to state law under Medicaid itself. *See Ark. Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S. 268, 279-80 (2006) (holding that Medicaid preempted state laws regarding liens on settlement agreements); *PhRMA*, 538 U.S. at 662-74 (examining whether a preliminary injunction was appropriate where state action was allegedly preempted by Medicaid); *Dalton v. Little Rock Family Planning Servs.*, 516 U.S. 474, 475 (1996) (per curiam) (discussing proper scope of injunctive

relief while declining to grant certification on the question whether the Hyde Amendment preempted contrary state laws).

B. A Remedy Under The Supremacy Clause Is Particularly Useful In Spending Clause Cases.

Despite the many cases allowing Spending Clause challenges, California and the Solicitor General argue that the only proper remedy is for the federal government to withhold funds from states that fail to comply with relevant federal law. Having reserved to the federal government the remedy of cutting off Medicaid funds (the argument goes), Congress must not have intended that the ultimate beneficiaries of those funds be able to sue when states take action inconsistent with federal law.

That argument turns the purpose of Medicaid on its head. Medicaid is a federal program "through which the Federal Government provides financial assistance to States so that they may furnish medical care to needy individuals." *Wilder v. Va. Hosp. Ass'n*, 496 U. S. 498, 502 (1990). Withholding federal funding would make it even less likely that those "needy individuals" would receive the medical care a state agreed to provide.

This Court considered a similar situation in *Rosado v. Wyman*, where it heard a lawsuit by individuals who received benefit payments from New York as part of Congress's Federal Aid To Families with Dependent Children program. 397 U.S. 397 (1970). The petitioner claimed that New York's method of distributing the benefits violated the terms on which the federal government provided the

funds to New York. *Id.* at 399. In holding that the petitioner had a right to proceed (and prevail), Justice Harlan wrote for the Court:

> We have considered and rejected the argument that a federal court is without power to review state welfare provisions or prohibit the use of federal funds by the States in view of the fact that Congress has lodged in the Department of HEW the power to cut off federal funds for noncompliance with statutory requirements. *We are most reluctant to assume Congress has closed the avenue of effective judicial review to those individuals most directly affected by the administration of its program.*

Id. at 420 (emphasis added).

So too here. Far from being unnecessary in Spending Clause cases, allowing for private attorneys general in this context is particularly useful to Congress. As the Solicitor General recognized in opposing certiorari in this case, "[a] system that relies solely on agency review may often be less effective in ensuring the supremacy of federal law than a system of agency review supplemented by private enforcement." SG Cert. Br. 19. Allowing for private enforcement provides a middle ground between doing nothing and cutting off funding. *See id.* (citing *Cannon v. Univ. of Chi.*, 441 U.S. 677, 705 (1979)). It assists executive agencies that may lack the resources to enforce in every individual case the obligations Congress imposes. It offers an alternate

avenue of relief to the months and even years of delay between when a state implements cuts and when the agency completes its review.[3] It provides some assurance that Congress's objectives will be realized even during administrations that may have different enforcement priorities. And in this case in particular, it provides impoverished Medicaid patients and the medical providers who serve them a means of redress in the court system that they would often not have in the political battles over budget cuts.

Put another way, there is no reason to think that Congress would have limited enforcement of Medicaid obligations to a remedy that would terminate those obligations. California has been accepting more than $20 billion in federal Medicaid funds per year in exchange for its promise, among other things, to ensure that needy patients had access to health care. Congress authorized the expenditure of those funds because it found that they would serve important public interests. That California has failed to adhere to its obligations is a

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[3] The delays in this case illustrate the problem. California waited until three months after it began cutting funds to submit its proposal to HHS. 09-958 Intervenor Resp. Br. 6. Two months after this submission, HHS requested that California submit additional information within 90 days. *Id.* The Secretary finally disapproved the plan twenty months after California failed to provide a response. *Id.* Currently, California is seeking reconsideration of this decision. *Id.* at 7. During this lengthy process, California has continued to implement the cuts except to the extent that it has been enjoined from doing so by the federal courts. *Id.*

reason to compel it do so, not a reason to abandon those interests by cutting off the program.

C. Congress Intends The Ultimate Beneficiaries Of Spending Clause Funds To Be Able To Obtain Equitable Relief When A State Fails To Comply With Its Obligations.

California and the Solicitor General also offer a cluster of arguments based on the fact that Respondents are not directly regulated by Section 30A, and instead receive their benefits from the state. Pet'r Br. at 46-48; SG Br. 16-24. These arguments are offered in an apparent attempt to distinguish this case from the many others allowing relief under the Supremacy Clause, but they have no bearing on what Congress should be presumed to have intended.

The Solicitor General, for example, emphasizes that Section 30A does not regulate respondents' "primary conduct," and that respondents are seeking a benefit promised by federal law rather than an "immunity" from state regulation. SG Br. at 22. California goes even further and contends that "[p]rinciples of supremacy, and of preemption generally, have no application to allegations that a state has failed to satisfy a federal funding condition." Pet'r Br. at 46.

But legislation, including Spending Clause legislation, may bestow benefits or provide immunities, and in both cases Congress intends that

those provisions be followed.[4] A state is no more free to withhold a benefit it agreed to bestow as a condition of taking a grant of federal funds than it is to violate the restrictive conditions attached to those funds.

This Court's recent decision in *PhRMA v. Walsh* is instructive. In *PhRMA*, a drug company trade association sought injunctive relief against a state that had imposed certain requirements on drug companies. The trade association argued that the state's program was inconsistent with the obligations it undertook as a condition of receiving Medicaid funds, and therefore preempted by federal law. The Solicitor General filed an amicus brief in favor of preemption, and only two members of the Court expressed any doubt that a private cause of action was permissible in that context.

California does not mention the *PhRMA* case even though it was central to the reasoning of the Court of Appeals. 10-283 Pet. App. 77-83. The Solicitor General acknowledges that *PhRMA* "could

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[4] For example, California simply does not address and the Solicitor General has great difficulty in explaining how this distinction works in light of this Court's decision in *Crosby*. *See* SG Br. 23 n.8. In attempting to classify *Crosby* as involving a "defense," the Solicitor General construes the deprivation of a benefit in that case– eligibility to be awarded a state contract – as a burden – the "exercise of the State's authority to impose and enforce what were essentially state regulatory standards." *Id.* But that simply collapses the purported distinction between denying benefits and imposing burdens, and demonstrates that the distinction cannot separate permissible Supremacy Clause claims from impermissible ones.

arguably be described as similar" to this case, but contends that it is distinguishable because "[t]he question in *PhRMA* was not whether the State had complied with obligations imposed on it as a condition of receiving federal Medicaid funds, but whether the State's use of Medicaid authority as a tool to impose [restrictions] on drug manufacturers ... was consistent with the Medicaid statute." SG Br. at 22, 24. But again, there is no reason to think that Congress would be more inclined to allow a state to fail to comply with "obligations imposed on it as a condition of receiving federal funds" than it would to allow a state to impose restrictions inconsistent with those obligations.

California and the Solicitor General also advert to contract analogies and contend that because the states are the direct recipients of the federal funds, the respondents in this case are reduced to third-party beneficiaries who have no right to sue to enforce compliance with the "contract." SG Br. at 25-26.

Amici respectfully disagree with this characterization. To be sure, the states are critical partners in providing care under Medicaid. But they are not the intended beneficiaries of Medicaid. Medicaid's purpose is to ensure that poor people also have access to basic medical care by guaranteeing payment to medical providers for serving this vulnerable population. And when a state fails to live up to its responsibilities to these beneficiaries, Congress intended to preserve the private cause of action for injunctive relief under the Supremacy

Clause as a limited but critical safeguard for these beneficiaries.

This Court's decision in *Pennhurst State School & Hospital v. Halderman*, 451 U.S. 1 (1981), supports a cause of action along precisely these lines, contrary to California's and the Solicitor General's reading of the case. Pet'r Br. 18, 46-48; SG Br. 27. Although this Court determined that the federal statute at issue did not create substantive rights to monetary relief or "'appropriate' treatment in the 'least restrictive' environment," 451 U.S. at 11, 29, this Court left open the possibility of injunctive relief. The majority explained that they would not "significantly differ" from (dissenting) Justice White's proposed remedy if the district court were to find on remand that the state had failed to comply with "federally imposed conditions," *id.* at 30 n.23. In turn, Justice White's dissent made clear that the only distinctive aspect of private suits under Spending Clause statutes seeking to vindicate the Supremacy Clause is the *scope* of the appropriate injunctive relief. *Id.* at 53-54 (White, J., dissenting). Justice White explained that such injunctions "cannot survive the State's decision to terminate its participation in the program." *Id.* This distinction matches the scope of the remedy to the contours of the preemption in these cases, which stretches only as far as the state's acceptance of federal funding. It comes into play after a determination on the merits; it certainly does not serve as a threshold bar to suit.[5]

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[5] To the extent the majority opinion can be read to limit the remedy to offering the State a choice between assuming the

Nor are California and the Solicitor General correct to argue that the "broad and non-specific" nature of the obligations imposed by Section 30A makes them inappropriate for an action seeking preemption. In the first place, this critique goes not to *whether* a cause of action exists in the first place, but to the *scope* of judicial relief available, This Court expressly limited the question presented in this case only to the first issue, and thus the second is not presented here.

Moreover, as the Solicitor General concedes, Section 30A's standards *are* enforceable in a judicial action where a State disagrees with the Secretary's disapproval of a State plan or amendment. *See* SG Br. at 31. If they are discernable in that context, it is difficult to see how they are unenforceable in the context of a private suit. Any remaining concerns about the need for agency input should be allayed by HHS's commitment "to conducting a rulemaking proceeding over the next year that will result in an authoritative interpretation of Section 1396a(a)(30)(A)." *See* SG Cert. Br. 8. As always, the agency's own interpretation will trump an inconsistent interpretation by a private party. *See id.* at 19 (citing *Nat'l Cable & Telecomms. Ass'n v. Brand X Internet Servs.*, 545 U.S. 967, 983 (2005)).

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additional cost of compliance or not using federal funds, *see id.* at 29, that is a question as to the scope of the remedy, not the right to seek relief in the first place. In any case, the majority's position is entirely consistent with the dissent's explanation that courts can only prospectively compel states to abide by federal conditions so long as the state continues to accept funding. *See id.* at 53-54 (White, J., dissenting).

III. THE HISTORY OF SECTION 30A DEMONSTRATES WITH PARTICULAR CLARITY THAT CONGRESS DID NOT INTEND TO FORECLOSE ACTIONS UNDER THE SUPREMACY CLAUSE.

That Petitioner and the Solicitor General would argue that Section 30A should be the first statutory provision ever to be found *not* to allow an action under the Supremacy Clause is particularly odd because the history of that provision demonstrates that Congress consciously chose not to limit its means of enforcement.

Section 30A in its current form dates back to 1989, and in the last 15 years it has been the subject of repeated, but unsuccessful, efforts in Congress to restrict private rights of action. These efforts stemmed from an earlier decision by this Court, *Wilder*, 4[illegible] U.S. at 509-10, which held that language similar to Section 30A, known as the "Boren Amendment" was enforceable under Section 1983.[6]

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[6] The Boren Amendment provided that

> a State plan for medical assistance must ... provide ... for payment ... of the hospital services, nursing facility services, and services in an intermediate care facility for the mentally retarded provided under the plan through the use of rates (determined in accordance with methods and standard developed by the State ...) *which the State finds, and makes assurances satisfactory to the Secretary, are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities* in order to provide care and services in conformity with applicable

Congress responded to this holding by considering whether to bar *all* private actions to enforce a state's payment rates under Medicaid, including those under Section 30A. For example, in 1995, the President vetoed Congress' attempt to prohibit any "cause of action" to enforce a state's payment rates under Medicaid, H.R. 2491, 104th Cong. § 7002(b)(4) (1995).[7] Congress did not attempt to override this veto. *See* Jennifer Suttle, Cong. Research Serv., CRS Report for Congress: Balanced Budget Act of 1995: A Legislative History and Brief Summary of H.R. 2491 CRS-8 (1996). In 1996, the Senate initially attempted to bar private suits again, but Congress ultimately enacted a statute without any such provision. *Compare* S. 1956, 104th Cong. § 1508 (1996) *and* Personal Responsibility and Work Opportunity Reconciliation Act of 1996, Pub. L. No. 104-193, 110 Stat. 2105.

Congress ultimately repealed the Boren Amendment in 1997, Pub. L. No. 105-33, § 4711(a), 111 Stat. 251, but it did *not* repeal Section 30A, nor did it add language restricting causes of action. This was no oversight. At the same hearing in which

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> State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access . . . to inpatient hospital services of adequate quality.

496 U.S. at 502-03 (emphasis added) (ellipses in original) (quoting 42 U.S.C. § 1396a(a)(13)(A) (1990)).

[7] President Clinton vetoed H.R. 2491 on December 6, 1995. Ann Devroy & Eric Pianin, *Clinton Vetoes GOP's 7-year Balanced Budget Plan*, WASH. POST, Dec. 7, 1995, at A1.

Congress heard criticism of the Boren Amendment, some witnesses also criticized litigation under Section 30A, which they deemed a "Boren-like" provision, s*ee Medicaid Reform: The Governors' View, Hearing of the H. Comm. on Commerce, Subcomm. on Health and Env't*, 105th Cong. 21 (1997) (prepared statement of Govs. Bob Miller and Michael O. Leavitt); *Governors' Perspective on Medicaid, Hearing Before the S. Comm. on Fin.*, 105th Cong. 37 (1997) (prepared statement of Govs. Bob Miller and Michael O. Leavitt).

California emphasizes that the accompanying report of the House Committee on the Budget stated that "[i]t is the Committee's intention that, following enactment of this Act, neither this nor any other provision of Section 1902 [the section containing Section 30A] will be interpreted as establishing a cause of action for hospitals and nursing facilities relative to the adequacy of the rates they receive." H.R. REP. NO. 105-149, at 591 (1997). But that report language does not track the actual text of the statute, which contains no prohibition of causes of action, and does not repeal Section 30A. And of course, it is the text of the statute that must prevail over a contrary passage of legislative history.

***

Congress remains free to amend the Medicaid statute to limit relief, shape relief, or to prohibit private causes of action altogether as Congress has done in other contexts when necessary. But there is nothing about Section 30A that makes it different from any of the other federal enactments that this

Court has permitted to be enforced under the Supremacy Clause. California agreed to provide a certain standard of benefits as a condition of receiving federal funds, and consistent with this Court's precedents, it is subject to equitable action if it fails to comply with those conditions.

CONCLUSION

For the foregoing reasons, the judgment of the Ninth Circuit should be affirmed.

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Nos. 09-958, 09-1158, and 10-283

In the Supreme Court of the United States

TOBY DOUGLAS, DIRECTOR OF THE
DEPARTMENT OF HEALTH CARE SERVICES,
STATE OF CALIFORNIA, PETITIONER
v.
INDEPENDENT LIVING CENTER OF SOUTHERN CALIFORNIA, INC.,
A NONPROFIT CORPORATION, ET AL.

TOBY DOUGLAS, DIRECTOR OF THE
DEPARTMENT OF HEALTH CARE SERVICES,
STATE OF CALIFORNIA, PETITIONER
v.
CALIFORNIA PHARMACISTS ASSOCIATION, ET AL.

TOBY DOUGLAS, DIRECTOR OF THE
DEPARTMENT OF HEALTH CARE SERVICES,
STATE OF CALIFORNIA, PETITIONER
v.
SANTA ROSE MEMORIAL HOSPITAL, ET AL.

ON WRITS OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

BRIEF OF *AMICI CURIAE* MICHIGAN AND 30 OTHER STATES SUPPORTING PETITIONER

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QUESTION PRESENTED

Whether Medicaid recipients and providers may maintain a cause of action under the Supremacy Clause to enforce § 1396a(a)(30)(A) by asserting that the provision preempts a state law that may reduce payments to providers.

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INTEREST OF *AMICI CURIAE*

The *amici* states administer jointly-funded federal-state programs, such as Medicaid, adoption assistance, and food assistance, in partnership with federal agencies. The financial impact of these programs on state budgets is astronomical. Take Medicaid, for instance. In fiscal year 2009, Michigan's total Medicaid spending exceeded $10.5 billion and consumed more than 18% of Michigan's general fund spending. The same year, California's total Medicaid spending exceeded $41.6 billion and consumed nearly 13% of California's general fund spending. And these costs are increasing far faster than inflation. In the midst of one of the country's worst economic crises in history, Medicaid spending nationwide rose from $338 billion in federal fiscal year 2007, to $359 billion in 2008, and to $387 billion in 2009.

Given the vast amounts of money at stake and the complexity of the Medicaid program, Congress has wisely delegated to the U.S. Department of Health & Human Services' Centers for Medicare & Medicaid Services (CMS) the authority to regulate this complex and highly technical subject matter, including provider-reimbursement rates. This litigation asks whether CMS will continue to be the arbiter of state Medicaid plans, or whether every discretionary decision states make in allocating Medicaid monies will instead be subject to enforcement by potentially millions of private litigants and court injunctions.

Here, the Ninth Circuit concluded that (1) there is no private right to enforce 42 U.S.C. § 1396a(a)(30)(A), but (2) the Supremacy Clause allows private litigants to sue anyway. Such a ruling, if affirmed, would invite

private litigants to sue the *amici* states not only over Medicaid-reimbursement decisions, but a whole host of other federal-state programs, contrary to Congress's intent. And the inevitable result of such lawsuits would be more court orders compelling the states to increase spending for the affected programs. Such judicial intervention destroys the delicate balance that Congress established between the states and federal agencies, creates significant risks to state budgets based on unpredictable court interpretations, and disrupts the smooth and efficient operation of federal-state programs.

The *amici* states respectfully request that the Court reverse the judgments below and affirm that it is inappropriate for the courts to allow private enforcement of a federal statute under the Supremacy Clause, when Congress has not clearly indicated in the statutory language its intent to create an individual right that a specific plaintiff may enforce.

INTRODUCTION AND SUMMARY OF ARGUMENT

This case raises the fundamental question of whether the Supremacy Clause can be used to privately enforce a federal statute after the courts have concluded that Congress did not intend private enforcement of that statute. Incredibly, the Ninth Circuit answered that question "yes." Pet. App. 83 ("a party may seek injunctive relief under the Supremacy Clause regardless of whether the federal statute at issue confers any substantive rights on would-be plaintiffs."). This Court should reverse for three reasons.

First, the Ninth Circuit's view usurps legislative authority. Only Congress has the power to create a private right of action to enforce a federal law. *Alexander* v. *Sandoval*, 532 U.S. 275, 286 (2001). Accordingly, when a statute does not display congressional intent to create both a private right and a private remedy, "a cause of action does not exist and courts may not create one, no matter how desirable that might be as a policy matter, or how compatible with the statute." *Id.* at 286–87.

Second, it is already well established by this Court's precedent that the Supremacy Clause, on its own, cannot create a cause of action when Congress has declined to do so. "[T]hat clause is not a source of any federal rights"; it "'secure[s]' federal rights by according them priority whenever they come in conflict with state law." *Golden State Transit Corp.* v. *City of Los Angeles*, 493 U.S. 103, 107 (1989) (quoting *Chapman* v. *Houston Welfare Rights Org.*, 441 U.S. 600, 613 (1979)). There is no compelling reason to overrule this well-settled precedent.

Third, the practical result of the Ninth Circuit's ruling is to transform private litigants into federal attorneys general of great destructive force, with the power to enforce their own interpretations of virtually any federal statute, regardless of whether Congress intended a private cause of action. Upholding the Ninth Circuit's decision would have a profound effect on principles of federalism and administrative deference, forcing the *amici* states to defend actions in circumstances where Congress chose to vest enforcement authority exclusively in an expert federal agency rather than private litigants. For all these

reasons, the *amici* states respectfully request that this Court reverse the Ninth Circuit and reaffirm that the Supremacy Clause does not provide private rights of action.

ARGUMENT

I. Only Congress has the power to create a private cause of action, and Congress declined to do so in § 1396a(a)(30)(A).

A. Under this Court's precedent, a plaintiff suing under a federal statute must show that Congress intended to create a private right of action to enforce that statute.

The question of whether a federal statute should be subject to private enforcement is a quintessential legislative judgment. "Like substantive federal law itself, private rights of action to enforce federal law must be created by Congress." *Alexander* v. *Sandoval*, 532 U.S. 275, 286 (2001). If federal courts were allowed to ignore congressional commands and choose for themselves which federal requirements may be enforced by private litigants, they would assume the legislative role, substituting their own intent for that of Congress. See *id.* at 287 ("'Raising up causes of action where a statute has not created them may be a proper function for common-law courts, but not for federal tribunals.'") (quoting *Lampf, Pleva, Lipkind, Prupis & Petigrow* v. *Gilbertson*, 501 U.S. 350, 365 (1991) (Scalia, J., concurring in part and concurring in the judgment)); *The Federalist No.* 78, at 466 (Alexander Hamilton) ("'there is no liberty, if the power of judging be not separated from the legislative and executive

powers'") (quoting Montesquieu, *The Spirit of the Laws*).

This Court's precedent has honored the vital distinction between legislative and judicial power in considering when causes of action exist to enforce federal rights. Beginning with *Cort* v. *Ash*, 422 U.S. 66, 78 (1975), this Court articulated a multi-factor test for determining when a federal statute is privately enforceable, identifying congressional intent as one of the primary considerations for determining whether a private remedy is implicit in a statute. *Id.* at 78 ("is there any indication of legislative intent, explicit or implicit, either to create such a remedy or to deny one?").

Only a few years later, in *Cannon* v. *Univ. of Chicago*, 441 U.S. 677 (1979), the Court reiterated the primacy of congressional intent, noting that "the right- or duty-creating language of the statute has generally been the most accurate indicator" of the existence of a private right of action. *Id.* at 690 n.13. Then-Justice Rehnquist's concurring opinion emphasized the primacy of the statutory language, stating, "The question of the existence of a private right of action is basically one of statutory construction." *Id.* at 717 (Rehnquist, J., concurring).

Two years later, the Court affirmed those principles in a pair of opinions, *Pennhurst State Sch. and Hosp.* v. *Halderman*, 451 U.S. 1 (1981), and *Cal.* v. *Sierra Club*, 451 U.S. 287 (1981). In holding that 42 U.S.C. § 6010 does not create substantive rights, this Court in *Pennhurst* concluded that the statute was designed to share responsibility between the federal government and the states. *Id.* at 22. Accordingly,

"Congress must express clearly its intent to impose conditions on the grant of federal funds so that the states can knowingly decide whether or not to accept those funds," particularly where a state faces potentially "indeterminate" obligations. *Id.* at 24. This Court noted that the typical remedy for a state's noncompliance with Spending Clause legislation was termination of funds by the federal agency. *Id.* at 28. Since states can only determine their federal obligations by reference to Congress's clearly-expressed intent, it follows that the states should not be saddled with private lawsuits where the statute does not provide for them. *Id.*

In *Sierra Club*, this Court refused to recognize a private right of action under 33 U.S.C. § 403. 451 U.S. at 289–90. Relying on the four-part *Cort* test, this Court held that § 403 enacted a general ban on certain activities; it did not focus on a particular class of beneficiaries nor did it confer any rights on a particular group. *Id.* at 294. Federal courts "will not engraft a remedy on a statute . . . that Congress did not intend to provide." *Id.* at 297.

Decisions in the 1990s further reinforced this precedent. E.g., *Suter* v. *Artist M.*, 503 U.S. 347, 350 (1992) (careful examination of the Adoption Assistance and Child Welfare Act's language showed that "the Act does not create an enforceable right."); *Blessing* v. *Freestone*, 520 U.S. 329, 341 (1997) (no private right of action under Title IV-D of the Social Security Act; in making that determination, the Court must focus "on congressional intent.").

The case law culminated in *Alexander* v. *Sandoval*, discussed above, and *Gonzaga Univ.* v. *Doe*, in which

this Court articulated a strict, three-part test to determine whether Congress created an individual right that a specific plaintiff may enforce under 42 U.S.C. § 1983. *Gonzaga Univ.* v. *Doe*, 536 U.S. 273, 283 (2002). Under that test, a statute only gives rise to a private right of action where it contains express rights-creating language, speaks in terms of individuals rather than institutional policy, and private enforcement is not incompatible with the statutory scheme. Only where Congress has spoken "in clear and unambiguous terms" does a party have a private right of action to enforce a Spending Clause statute.[1] *Id.* at 290.

In sum, this Court's jurisprudence appropriately looks to congressional intent as expressed in the plain, statutory language to determine whether Congress created an individual right that a specific plaintiff may enforce. Separation-of-power principles could survive nothing less. This Court should reject the Ninth Circuit's approach, a regime that would render congressional intent irrelevant and wholly subservient to the self-serving statutory interpretations of private parties backed by court injunctions.

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[1] See also *Verizon Md. Inc.* v. *Public Serv. Comm'n*, 535 U.S. 635, 644 (2002), where this Court observed: "nothing in the Act displays any intent to withdraw federal jurisdiction under § 1331; we will not presume that the statute means what it neither says nor fairly implies." The courts thus look to *Congress* to identify whether a particular statute confers a private of action.

B. Congress did not intend to create a private right of action for alleged violations of § 1396a(a)(30)(A).

Seven of the eight Circuits that have addressed the question since this Court decided *Gonzaga* have concluded that Congress did *not* intend that Medicaid providers or beneficiaries would have the right to enforce § 1396a(a)(30)(A) in a § 1983 action. *Long Term Care Pharmacy Alliance* v. *Ferguson*, 362 F.3d 50, 56–59 (1st Cir. 2004) (not enforceable by providers); *N.Y. Ass'n of Homes & Servs. for the Aging, Inc.* v. *DeBuono*, 444 F.3d 147 (2d Cir. 2006) (not enforceable by providers); *Pa. Pharmacists Ass'n* v. *Houstoun*, 283 F.3d 531, 541–42 (3d Cir. 2002) (not enforceable by providers) (Alito, J.); *Equal Access for El Paso, Inc.* v. *Hawkins*, 509 F.3d 697, 702–03 (5th Cir. 2007) (not enforceable by beneficiaries of services or providers); *Westside Mothers* v. *Olszewski*, 454 F.3d 532, 541–43 (6th Cir. 2006) (not enforceable by providers or recipients of services); *Sanchez* v. *Johnson*, 416 F.3d 1051, 1062 (9th Cir. 2005) (not enforceable by providers or recipients of services); *Manday R. ex rel. Mr. & Mrs. R.* v. *Owens*, 464 F.3d 1139, 1146–48 (10th Cir. 2006) (not enforceable by providers or recipients of services); but see *Pediatric Specialty Care, Inc.* v. *Ark. Dep't of Human Servs.*, 443 F.3d 1005, 1013–16 (8th Cir. 2006).[2] And while Congress has the power to respond to these rulings by changing the law to create private rights of action, it has steadfastly refused to do

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[2] In *Minnesota Pharmacists Assoc.* v. *Pawlenty*, 690 F. Supp. 2d 809 (D. Minn. 2010), the court concluded that the Eighth Circuit's holding in *Pediatric Specialty Care*—that § 1396a(a)(30)(A) is privately enforceable—is inconsistent with this Court's decision in *Gonzaga*.

so, despite undertaking the broadest overhaul of healthcare regulation in the nation's history.

That congressional prerogative is well founded. When a state administers a public assistance program in conjunction with a federal agency, that agency should be the principal enforcer of the statute, regulations, and other directives. Each such federal agency has multiple tools to assure the state's compliance, the principal of which is its authority to withhold federal funds. Although Congress may intend that particular statutory provisions be subject to private enforcement through litigation, such lawsuits should be strictly limited to those based on provisions that unambiguously provide for private enforcement. 42 U.S.C. § 1396a(a)(30)(A) is not one of these provisions. Nor does the Supremacy Clause magically endow Medicaid providers and recipients with the authority to enforce this provision.

Instead, applying this Court's precedent, a private party can only secure judicial enforcement of provisions in which Congress has created an individual "right" that is enforceable by that party. Regardless of whether a plaintiff seeks to pursue his or her claim under the federal statute directly, § 1983, or any other potential vehicle, such enforcement should only be allowed to proceed consistent with congressional intent. Any other outcome would mean that important political questions are resolved outside the open debate of the democratic process. Such a debate at the time of § 1396a(a)(30)(A)'s enactment, for example, would have assuredly been robust had anyone suggested that Medicaid providers had a private right of action to enforce the provision.

II. The Supremacy Clause should not be used to create a private right of action where Congress chose not to provide one.

In *Golden State Transit Corp.* v. *City of Los Angeles*, this Court expressly rejected the Supremacy Clause as a source of any privately enforceable rights. *Golden State Transit Corp.* v. *City of Los Angeles*, 493 U.S. 103, 107–10 (1989). Specifically, the Court stated that "the Supremacy Clause, of its own force, does not create rights enforceable under § 1983." Rather, the Supremacy Clause merely "'secure[s]' federal rights by according them priority whenever they come in conflict with state law." *Id.* at 107 (quoting *Chapman* v. *Houston Welfare Rights Org.*, 441 U.S. 600, 613 (1979)).

It would therefore "obviously be incorrect" to recognize a federal right of action whenever a federal statute or regulation preempts state law. *Golden State*, 493 U.S. at 108. A party may not invoke the Supremacy Clause to provide a rule of decision unless he or she is otherwise properly before the court. Accord, e.g., *Chapman* v. *Houston Welfare Rights Org.*, 441 U.S. 600, 613 (1979) (noting that the Supremacy Clause "'secure[s]' federal rights by according them priority whenever they come in conflict with state law").

The Court should not revisit its Supremacy Clause precedent. If the Supremacy Clause, on its own, created a stand-alone action based on preemption, then every provision in the United States Code would implicitly authorize a private cause of action against a state or local governmental defendant. As discussed in Section I, *supra*, such a concept would usurp

Congress's authority to say not only what the law is, but who has the right to enforce it.

Equally important, the Ninth Circuit's interpretation of the Supremacy Clause intrudes on executive branch authority. Here, as in many federal-state partnerships, Congress authorized an expert agency to interpret and enforce statutory requirements not only by promulgating regulations, but by approving state plans. E.g., 42 U.S.C. § 1396a(a) (to qualify for federal financial assistance, participating Medicaid states must submit to the Secretary, and the Secretary must approve, "a plan for medical assistance").[3]

Under the Ninth Circuit's reasoning, however, every person or entity with standing is a private attorney general, able to enforce federal statutes or regulations whenever someone believes a state is violating federal law. Allowing a Supremacy Clause action requires the federal courts to resolve questions that Congress thought best suited to resolution by federal agencies with technical knowledge and firsthand experience in the regulated area. Moreover, private litigation will inevitably produce inconsistent

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[3] In other words, no state or state official violates federal law by administering a Medicaid program that fails to qualify for federal reimbursement. Nor do they violate federal law by provoking or daring the Secretary to withhold federal funds. It is impossible for state officials to "violate" the Medicaid Act. Only the Secretary can violate the Act—by approving federal reimbursement for a state program that fails to satisfy the criteria listed in 42 U.S.C. § 1396a. Accord *Pennhurst*, 451 U.S. at 28 ("In legislation enacted pursuant to the spending power, the typical remedy for state noncompliance with federally imposed conditions is not a private cause of action for noncompliance but rather action by the Federal Government to terminate funds to the State.").

results in an area where Congress delegated enforcement authority to a federal agency to ensure uniformity. Cf. *Conboy* v. *AT&T Corp.*, 241 F.3d 242, 253 (2d Cir. 2001) ("[A] private right of action would place the [agency's] 'interpretative function squarely in the hands of private parties and some 700 federal district judges, instead of in the hands of the [agency and] . . . would . . . deprive the [agency] of necessary flexibility and authority in creating, interpreting, and modifying . . . policy.'") (quoting *New England Tel. & Tel. Co.* v. *Public Utils. Comm'n*, 742 F.2d 1, 6 (1st Cir. 1984) (Breyer, J.).

These considerations militate strongly in favor of maintaining the Court's precedent and the Framers' vision: the Supremacy Clause is a choice-of-law provision, not an affirmative grant of individual rights.

III. Allowing "Supremacy Clause lawsuits" to enforce federal Medicaid laws will be a financial catastrophe for states.

Principles of agency deference and separation of powers militate strongly against a regime whereby federal courts may thwart congressional will and create causes of action via the Supremacy Clause. But conditions on federal funding also implicate federalism, a concern heightened by the *amici* states' current fiscal crisis and the vast size of their Medicaid programs.

Only two years ago, this Court emphasized that federal courts should be cautious when dictating how states spend their limited funds:

> Federalism concerns are heightened when, as in these cases, a federal court decree has the

> effect of dictating state or local budget priorities. States and local governments have limited funds. When a federal court orders that money be appropriated for one program, the effect is often to take funds away from other important programs.

Horne v. *Flores*, 129 S. Ct. 2579, 2593–2596 (2009).[4]

The reality is that many states continue to experience severe budget shortfalls. In 2010-11, 43 states face budget shortfalls ranging up to 30% of their general fund budgets: "While states attempted to close their budget gaps through a variety of measures, including budget cuts, tax increases or taking money from rainy day funds, they face at least a combined $127 billion gap through fiscal 2012."[5]

Meanwhile, Medicaid budgets are growing rapidly: "During the worst economic downturn our nation has experienced since the great depression, national Medicaid spending rose from $338 billion in federal

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[4] The Court cited the Equal Educational Opportunities Act, which requires states to take "appropriate action to overcome language barriers" in schools, 20 U.S.C. § 1703(f). 129 S. Ct. at 2588.

[5] Http://sunshinereview.org/index.php/State_budget_issues,_2010-2011# (as visited 3/29/11) ("In addition, the funds given to states also included large expansion of Medicaid to cover the health care of unemployed workers and single workers without children. In 2011, when the federal funds run out, states will be stuck with one million more people on Medicaid with no money to pay for it. The estimated increase from the temporary increase in the Federal Medicaid Assistance Percentage (FMAP) from ARRA is $87 billion over the 27 months which began October 2008 and ends December 2010. Medicaid enrollment increased by 6.0 percent during fiscal 2009.").

fiscal year 2007 to $359 billion in 2008 and to $387 billion in 2009. This represents increases of 6.4 percent and 7.7 percent respectively."[6] Faced with this financial tsunami, the *amici* states must make difficult choices regarding the programs they administer.

One of these critical choices involves the states' costs for maintaining their Medicaid programs, which increase because: (A) the costs of health care are rising nationwide;[7] and (B) the number of persons eligible for Medicaid is increasing. States may seek to reduce their Medicaid costs through several means, e.g., cuts in provider-reimbursement rates or the elimination of "optional" areas of Medicaid coverage. As a rule, if these proposed reductions are acceptable to the U.S. Department of Health & Human Services' Centers for Medicare & Medicaid Services (CMS), the states may implement them without judicial intervention.

But under the Ninth Circuit's approach, parties may obtain judicial court rulings, and obtain court injunctions, even before CMS has had a chance to review the state action at issue and provide its own interpretation. In the present cases, for example, California has been compelled to pay more than one billion dollars in additional Medicaid funds pursuant to

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[6] http://www.kff.org/medicaid/upload/8152.pdf (as visited 3/29/11), at p. 1.

[7] In Michigan, "Federal Funds Information for States (FFIS) has estimated the gross cost of the Medicaid expansion in Michigan to be $1.8 billion by 2017 and $2.0 billion by 2019." Michigan State Fiscal Agency, "Fiscal Analysis of The Federal Health Reform Legislation," April 2010, http://www.senate.michigan.gov/sfa/Publications/Issues/HealthReform/FedHealthReformLegislation.pdf (as visited 3/29/11), at p. 5.

court interpretations of § 1396a(a)(30)(A) that the federal government has rejected. Such a regime creates immense budgetary uncertainty at a time when states can least afford it. And the Ninth Circuit's approach places the power of enforcement in the hands of millions of potential private parties rather than the federal agency that Congress chose to regulate the technical and complex Medicaid program. The courts should respect Congress's decision to leave Medicaid enforcement to CMS, and private enforcement of federal statutes should be limited to those where Congress has unambiguously created a private right of action.

CONCLUSION

The judgments below should be reversed.

Respectfully submitted,

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Dated: MAY 2011

RECORD
AND
BRIEFS

Nos. 09-958, 09-1158, 10-283

In The Supreme Court of the United States

TOBY DOUGLAS, DIRECTOR
CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES,
PETITIONER

v.

INDEPENDENT LIVING CENTER OF SOUTHERN
CALIFORNIA, INC., ET AL.

AND

CALIFORNIA PHARMACISTS ASSOCIATION, ET AL.

AND

SANTA ROSA MEMORIAL HOSPITAL, ET AL.

ON WRITS OF CERTIORARI TO THE
UNITED STATES SUPREME COURT OF APPEALS FOR THE
NINTH CIRCUIT

BRIEF OF THE NATIONAL ASSOCIATION OF CHAIN DRUG STORES, NATIONAL COMMUNITY PHARMACISTS ASSOCIATION, NATIONAL ALLIANCE OF STATE PHARMACY ASSOCIATIONS AND THE AMERICAN PHARMACISTS ASSOCIATION AS *AMICI CURIAE* SUPPORTING RESPONDENTS

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QUESTION PRESENTED

Whether the Supremacy Clause supports an equitable cause of action under the Constitution, to prevent injury to Medicaid beneficiaries and providers, by enjoining state officials to refrain from implementing state legislation that contravenes 42 U.S.C. § 1396a(a)(30)(A) of the federal Medicaid Act.

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INTEREST OF *AMICI CURIAE*[1]

Amici—the National Association of Chain Drug Stores, the National Community Pharmacists Association, the National Alliance of State Pharmacy Associations, and the American Pharmacists Association—are national pharmacy and pharmacists associations whose members include national and community pharmacy providers who serve Medicaid beneficiaries.

In this case, the Court will decide whether the U.S. Court of Appeals for the Ninth Circuit correctly held that the Supremacy Clause provides a private right of action to third parties to challenge State laws preempted by federal law. The associations represent providers who participate in the Medicaid Program and who would be adversely impacted if the Court foreclosed their ability to challenge State action that is preempted by federal law, particularly as it relates to the Medicaid Program. For these reasons, *amici* have a substantial interest in this case and a unique perspective on its proper resolution.

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[1] No counsel for a party authored this brief in whole or in part, and no counsel for a party or party made a monetary contribution intended to fund the preparation or submission of this brief. Other than *amici curiae*, their members, or their counsel, no party made a monetary contribution to this brief's preparation or submission. The parties have consented to the filing of this brief.

INTRODUCTION AND SUMMARY OF ARGUMENT

Medicaid is a joint federal and State program created under Title XIX of the Social Security Act to provide health care coverage to indigent and otherwise disadvantaged Americans in States that voluntarily elect to participate. 42 U.S.C. § 1396 *et seq.* Federal and State government agencies share responsibility for funding Medicaid. *Id.* § 1396a(a). Each State administers its own Medicaid program in accordance with federal and State law and pursuant to a Medicaid State Plan which the United States Department of Health and Human Services Centers for Medicare and Medicaid Services ("CMS") reviews and approves. 42 C.F.R. § 430.10 *et seq.* States participating in the Medicaid program may provide coverage for pharmacy services. 42 U.S.C. § 1396a. All fifty States have chosen to do so.

In order to comply with federal law, a State which chooses to participate in the Medicaid program must comply with the "quality of care" clause of 42 U.S.C.§ 1396a(a)(30)(A), which provides in pertinent part:

> A state plan for medical assistance must— . . . provide such methods and procedures relating to the utilization of, and payment for, care and services available under the plan . . . as may be necessary. . . to assure that payments are consistent with efficiency, economy, and quality of care . . . .

42 U.S.C. § 1396a(a)(30)(A) ("Section 30(A)").

A State Medicaid program must also comply with the "access" clause of Section 30(A), which provides in pertinent part:

> A state plan for medical assistance must— . . . provide such methods and procedures relating to the . . . payment for, care and services available under the plan . . . as may be necessary. . . to assure that payments . . . are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area . . . .

Id.

When States change how they set rates for Medicaid reimbursement to reduce the costs of their Medicaid programs, they frequently reduce payment rates to providers of medical services to Medicaid enrollees. Although Medicaid beneficiaries suffer the greatest injuries when States reduce payment for services because they lose access to needed care, providers are often the first to suffer the associated financial consequences. These reductions, when made without any analysis of their corresponding impact on providers and beneficiaries, run afoul of Section 30(A). *See* Medicaid Program; Methods for Assuring Access to Covered Medicaid Services, 76 Fed. Reg. 26342 (proposed May 6, 2011) (to be codified at 42 C.F.R. pt. 447). Therefore, if the law setting rates does not provide payments sufficient to assure "access" and "quality of care," federal law,

pursuant to the Supremacy Clause of the United States Constitution, preempts that State law.

Principles of federalism mandate the supremacy of federal law. This Court has long assumed that there is a generally available right of action for preemption claims not derived directly from statute or from 42 U.S.C. § 1983 but from the Constitution. This Court should now expressly recognize that preemption claims brought under the Supremacy Clause are necessary to assure the supremacy of federal law.

ARGUMENT

I. The Federal Constitution Is the Supreme Law of the Land

Federalism is a system of government in which power is divided and shared among a national government, state governments, and local governments. The States agreed to a federalist model of government when they ratified the United States Constitution. Under the federal constitution the States affirmatively ceded certain powers to the federal government while retaining others. Article VI, clause 2 of the federal constitution (the "Supremacy Clause") guarantees the national union of the States by mandating that the Constitution, federal laws, and treaties take precedence over State law and binds all judges to adhere to that principle in their courts. Specifically, the Supremacy Clause provides:

> This Constitution, and the Laws of the United States which shall be made in Pursuance thereof; and all Treaties

> made, or which shall be made, under the Authority of the United States, shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any state to the Contrary notwithstanding.

U.S. Const., art. VI, cl. 2.

James Madison in advocating for ratification of the Constitution argued that the Supremacy Clause was necessary because State legislatures were invested with all powers not specifically defined in the Constitution. Therefore, absent the Supremacy Clause, the federal constitution would be subservient to various State constitutions. The Federalist No. 44, at 180-84 (James Madison) (Wilder Pub. 2008). In further support of the Supremacy Clause, he argued "as the constitutions of the States differ much from each other, it might happen that a treaty or national law, of great and equal importance to the States, would interfere with some and not with other constitutions, and would consequently be valid in some of the States, at the same time that it would have no effect in others." *Id.* at 183. Madison concluded that this would lead to an inverse result with a national government ruled by the States or "a monster, in which the head was under the direction of the members." *Id.* Accordingly, the Supremacy Clause was needed to clearly delineate the competing authorities of the federal and State governments, and by ratifying the United States Constitution the States agreed that in cases of conflict between federal and State law, federal law is supreme.

II. There Is a Cause of Action Under the Supremacy Clause of the Constitution

Alexander Hamilton also defended the Supremacy Clause, stating "[a] *law*, by the very meaning of the term, includes supremacy" because "[i]t is a rule which those to whom it is prescribed are bound to observe." The Federalist No. 33, at 123 (Alexander Hamilton) (Wilder Pub. 2008). If laws were not supreme "[i]t is evident they would amount to nothing." *Id.* Thus, although laws by their nature imply their supremacy, the Supremacy Clause assures that federal laws will be properly executed and will take priority over conflicting State laws. Accordingly, the drafters of the United States Constitution believed that the Supremacy Clause was necessary so that the States affirmatively acknowledged the supremacy of federal law. By ratifying the United States Constitution the States agreed to the supremacy of federal law against conflicting State laws. For the Supremacy Clause to have any meaning, there must be a private right of action to address situations when States enact laws which conflict with federal law.

A. This Court Has Long Recognized a Cause of Action Under the Constitution.

While this Court has refused to imply a cause of action in federal statutes, the Court has consistently recognized causes of action under the United States Constitution. In *Davis v. Passman*, 442 U.S. 228 (1979), Justice Brennan set forth an exposition of jurisdiction, standing, cause of action, and remedies:

> Thus it may be said that *jurisdiction* is a question of whether a federal court has the power, under the Constitution or laws of the United States, to hear a case, *see Mansfield, C. & L. M. R. Co. v. Swan*, 111 U.S. 379, 384 (1884); *Montana-Dakota Utilities Co. v. Northwestern Public Serv.* Co., 341 U. S. 246, 249 (1951); *standing* is a question of whether a plaintiff is sufficiently adversary to a defendant to create an Art. III case or controversy, or at least to overcome prudential limitations on federal-court jurisdiction, *see Warth v. Seldin*, 422 U. S. 490, 498 (1975); *cause of action* is a question of whether a particular plaintiff is a member of the class of litigants that may, as a matter of law, appropriately invoke the power of the court; and *relief* is a question of the various remedies a federal court may make available. A plaintiff may have a cause of action even though he be entitled to no relief at all, as, for example, when a plaintiff sues for declaratory or injunctive relief although his case does not fulfill the "preconditions" for such equitable remedies. *See Trainor v. Hernandez*, 431 U. S. 434, 440-443 (1977).

Id. at 239 n.18. In *Davis*, the Court was asked to determine whether the U.S. Court of Appeals for the Fifth Circuit correctly determined that a cause of action and a damages remedy did not exist under the

Constitution for violations of the Due Process Clause of the Fifth Amendment. *Id.* at 230. In reversing the Court of Appeal's decision, this Court held that the Court of Appeals used the wrong criteria to determine whether the petitioner should be able to enforce the Fifth Amendment's Due Process Clause. The Court explained that the Court of Appeals erred by applying the "criteria set out in *Cort* v. *Ash*, 422 U. S. 66 (1975), for ascertaining whether a private cause of action may be implied from 'a statute not expressly providing one.'" The Court noted that "the question of who may enforce a statutory right is fundamentally different from the question of who may enforce a right that is protected by the Constitution." *Id.* at 241-43.

Instead, this Court found that there is a cause of action in the Constitution to enforce constitutional rights, with jurisdiction conferred by the federal question statute. *Id.* The Court noted that:

> [t]he Constitution . . . does not 'partake of the prolixity of a legal code.' *McCulloch* v. *Maryland*, 4 Wheat. 316, 407 (1819). It speaks instead with a majestic simplicity. One of 'its important objects,' *ibid.*, is the designation of rights. And in 'its great outlines,' *ibid.*, the judiciary is clearly discernible as the primary means through which these rights may be enforced.

Similarly, this Court has recognized a cause of action in cases which assert that federal law preempts a conflicting State law or regulation.

> It is beyond dispute that federal courts have jurisdiction over suits to enjoin state officials from interfering with federal rights. See *Ex parte Young*, 209 U.S. 123, 160-162, 28 S.Ct. 441, 454-455, 52 L.Ed. 714 (1908). A plaintiff who seeks injunctive relief from state regulation, on the ground that such regulation is pre-empted by a federal statute which, by virtue of the Supremacy Clause of the Constitution, must prevail, thus presents a federal question which the federal courts have jurisdiction under 28 U.S.C. § 1331 to resolve. See *Smith v. Kansas City Title & Trust Co.*, 255 U.S. 180, 199-200 (1921); *Louisville & Nashville R. Co.* v. *Mottley*, 211 U.S. 149, 152, (1908); *see also Franchise Tax Board*, ante, at 19-22 and n. 20; Note, *Federal Jurisdiction Over Declaratory Suits Challenging State Action*, 79 Colum. L. Rev. 983, 996-1000 (1979). This Court, of course, frequently has resolved pre-emption disputes in a similar jurisdictional posture. See, *e.g.*, *Ray* v. *Atlantic Richfield Co.*, 435 U.S. 151 (1978); *Jones* v. *Rath Packing Co.*, 430 U.S. 519 (1977); *Florida Lime & Avocado Growers, Inc.* v. *Paul*, 373 U.S. 132 (1963); *Hines* v. *Davidowitz*, 312 U.S. 52 (1941).

Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 96 n.14 (1983).

Since *Shaw*, this Court has recognized a cause of action where a plaintiff seeks prospective declaratory or injunctive relief under the Supremacy Clause to prevent State legislators from enacting laws preempted by a federal statute. This Court has decided the merits of these preemption cases without addressing whether the allegedly preemptive federal statute grants a private right of action to the plaintiff. *See, e.g., Lorillard Tobacco Co. v. Reilly*, 533 U.S. 525 (2001) (tobacco manufacturers and retailers sued Massachusetts to enjoin enforcement of State cigarette advertising restrictions on the ground that the federal Cigarette Labeling and Advertising Act preempts State regulation); *United States v. Locke*, 529 U.S. 89 (2000) (United States alleges that Washington State statute governing the design of oil tankers is preempted by federal statute); *Crosby v. Nat'l Foreign Trade Council*, 530 U.S. 363 (2000) (National Foreign Trade Council sues to enjoin enforcement of Massachusetts law that barred procurement from companies that did business with Burma on preemption grounds); *Foster v. Love*, 522 U.S. 67 (1997) (Louisiana voters challenge State law governing elections as being preempted by federal election statute). Like *Davis v. Passman*, these cases demonstrate that this Court will permit injunctive or declaratory relief on a basis of federal preemption without regard to whether the federal statute provides a private right of action.

This Court's preemption analysis was set forth in *Verizon Maryland., Inc. v. Pub. Serv. Comm'n. of Maryland*, 535 U.S. 635 (2002). In *Verizon*, this Court unanimously reached the merits of a preemption claim while "express[ing] no opinion"

whether there was a private cause of action to enforce the federal telecommunications law even though the State argued that there was no private cause of action in the statute, and therefore, no jurisdiction for the suit. This Court responded to the State's challenge by stating:

> We need express no opinion on the premise of this argument. "It is firmly established in our cases that the absence of a valid (as opposed to arguable) cause of action does not implicate subject-matter jurisdiction, *i.e.*, the courts' statutory or constitutional *power* to adjudicate the case."

Id. at 642-43 (quoting *Steel Co. v. Citizens for Better Env't*, 523 U.S. 83, 89 (1998)).

This Court found that nothing in the 1996 Telecommunications Act "purports to strip [federal question] jurisdiction." *Id.* at 643. Rather, this Court concluded: "[i]n sum, nothing in the Act displays any intent to withdraw federal jurisdiction under § 1331; we will not presume that the statute means what it neither says nor fairly implies." *Id.* at 644. Therefore, this Court found that federal question jurisdiction existed, because the law "does not distinctively limit the substantive relief available." *Id.* Specifically, this Court stated that as long as the plaintiff's preemption claim is not frivolous, the district court has federal question jurisdiction to determine whether a State regulation is preempted by federal law, pursuant to the Supremacy Clause. *Id.* at 643. As such, this Court summarily dismissed

the argument that the lack of a cause of action could affect the federal judicial power to adjudicate the plaintiff's preemption claim.

Similarly, in two subsequent Medicaid decisions, this Court reached the merits of preemption questions by assuming, without discussion, the existence of a cause of action. For example, *Pharmaceutical Research & Manufacturers of America v. Walsh*, 538 U.S. 644 (2003) (hereinafter "*PhRMA*"), concerned whether Maine's prescription drug law was preempted by the federal Medicaid statute. In that case, PhRMA sought to enjoin Maine officials from implementing a drug rebate program devised to obtain discounted drug prices for persons not covered by Medicaid. Under the terms of the program, pharmaceutical companies that refused to participate in Maine's drug rebate program were required to submit their drugs to prior authorization procedures under the State's Medicaid Program. *Id.* at 649-50. This Court "assumed *sub silentio* that the plaintiff had a right of action for its claim that the Medicaid statute preempted state law." David Sloss, *Constitutional Remedies for Statutory Violations*, 89 Iowa L. Rev. 355, 374 (2004).

In a second Medicaid case, *Arkansas Dept. of Health & Human Services v. Ahlborn*, 547 U.S. 268 (2006), this Court unanimously held that an Arkansas statute requiring Medicaid applicants to assign to the State the entirety of any settlement violates the federal Medicaid law's "anti-lien statute," and that the State may recover only from those portions of third party awards allocated for medical expenses. This Court unanimously held

that State law conflicted with federal law and was therefore unenforceable under the Supremacy Clause. Again, as in the *PhRMA* case, this Court reached the merits of the preemption claim without addressing the issue of federal jurisdiction, which was presumed.

B. Principles of Federalism Support a Cause of Action Under the Supremacy Clause

The presumption in favor of a cause of action under the Supremacy Clause is justified by the federal interests underlying the Supremacy Clause—the supremacy of federal law and the need to keep State officials within the bounds of the federal law. Without a cause of action under the Supremacy Clause there would be limited means to address systemic violations of federal laws by State officials. The federal government has finite litigation resources and cannot effectively monitor each State's law to assure that it does not conflict with federal law.[2] Absent judicial resolution of preemption claims, States would presumably continue to enforce

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[2] To expect the federal government to monitor all State laws to assure that there is no conflict would impose exactly the federal "negative" option which the Convention rejected. *See*, Brief of the Nat'l Governors Assoc et al. as Amici Curiae in Support of Petitioner, p. 15-17. Rather, recognizing a private cause of action under the Supremacy Clause assures that the power of State legislatures to pass needed legislation is only intruded upon when that legislation conflicts with federal law and the State law has imposed a "concrete, particular, and redressable" injury on a party.

laws which conflict with federal laws.[3] Allowing third parties to bring preemption claims is consistent with federal supremacy and the goal of keeping State and federal law in harmony.

As this Court recently stated, "'[F]ederalism secures to citizens the liberties that derive from the diffusion of federal power.'" *Bond v. United States*, 564 U.S. __, No. 09-1227, slip. op. at 9 (June 16, 2011) (quoting *New York v. United States*, 505 U.S. 144, 181 (1992)).

> Federalism also protects the liberty of all persons within a State by ensuring that laws enacted in excess of delegated governmental power cannot direct or control their actions. By denying any one government complete jurisdiction over all the concerns of public life, federalism protects the liberty of the individual from arbitrary power. When government acts in excess of its lawful powers, that liberty is at stake.
>
> The limitations that federalism entails are not therefore a matter of rights belonging only to the States. States are not the sole intended beneficiaries of federalism. An individual has a direct interest in objecting to laws that upset

---

[3] This case is a prime example. Absent a private cause of action under the Supremacy Clause that provided an entry to federal court, California claims that it could have implemented AB 5 and AB 1183 before and even after HHS found the reductions mandated by AB 5 and AB 1183 did not comply with federal law.

> the constitutional balance between the National Government and the States when the enforcement of those laws causes injury that is concrete, particular, and redressable. Fidelity to principles of federalism is not for the States alone to vindicate.

Bond, at 9-10.

> If the constitutional structure of our Government that protects individual liberty is compromised, individuals who suffer otherwise justiciable injury may object.
>
> Just as it is appropriate for an individual, in a proper case, to invoke separation-of-powers or checks-and-balances constraints, so too may a litigant, in a proper case, challenge a law as enacted in contravention of constitutional principles of federalism.

Id., at 11 (citations omitted).

If Petitioner's views prevail, citizens would lose the ability to challenge State laws that conflict with federal laws. As the Court noted in *Davis v. Passman*, actions premised on a violation of the Constitution are distinct from private causes of action brought against private defendants. With respect to private actions, this Court made clear in *Cort v. Ash*, *supra*, that there is a presumption against a statutory implied right of action for claims against private defendants; however, in *Davis v. Passman*, *supra*, this Court drew a clear distinction

between implied causes of actions for violations of statutes as opposed to violations of Constitutional protections. The distinction is logical since actions against private defendants charged with federal statutory violations do not implicate any competing State interests. Thus, the *Shaw* preemption cases, discussed *supra*, which permit injunctive relief only against State officials, can be justified by principles of federalism and federal supremacy objectives whereas suits against private defendants do not serve the same objectives.

Moreover, a right of action under the Supremacy Clause does not violate Constitutional separation of powers principles. In contrast to the legislature's proper role of providing enforcement mechanisms for statutory rights, developing constitutional remedies is largely a judicial function. Based on this Court's consistent acceptance of preemption claims, Congress may very well have rightly assumed that an express cause of action for preemption of State laws is unnecessary because the existing jurisprudence provides injunctive relief in successful preemption cases, regardless of whether the underlying federal statute provides an express cause of action. Any claim that Congress must establish a cause of action before an individual can "challenge a law as enacted in contravention of constitutional principles of federalism" lacks merit. *Bond*, slip. op. p. 11. "The Supremacy Clause on its face makes Federal law 'the supreme Law of the Land' even absent an express statement by Congress." *Pliva v. Mensing*, 564 U.S. __, No. 09-993, slip op. at 14 (June 23, 2011) (quoting U.S. Const., art. VI, cl. 2.).

In sum, recognition of a cause of action under the Supremacy Clause is justified by federal supremacy and rule of law objectives and ensures that State and local government officers do not systematically violate federal statutes.

III. A Cause of Action Under the Supremacy Clause Is Particularly Important in Medicaid Cases

If this Court determines that the Supremacy Clause does not provide individuals with a private cause of action, then individuals will have no judicial recourse in cases where federal law preempts laws enacted by State legislatures. For instance, the genesis of these consolidated cases are actions taken by California in 2008 with regard to its Medicaid Program which illustrate the importance of expressly affirming a private right of action under the Supremacy Clause. Among other rate reductions, California attempted to institute a ten percent rate reduction for pharmacy services. Assembly Bill 5, 3d extraordinary sess. (Cal. 2008) ("AB 5") (No. 09-1158, Pet. App. 190-97.) AB 5 never went into effect due to the preliminary injunction entered by the district court premised on a finding that respondents had a private right of action under the Supremacy Clause. California then adopted a five percent reduction on pharmacy reimbursement. Assembly Bill 1183 (Cal. 2008) ("AB 1183") (No. 09-1158, Pet. App. 198-217). The AB 1183 reductions also never went into effect and have been superseded by subsequent legislation. *See* No. 09-1158, Pet. Br. at 9 n.3.

Nearly two years after the State enacted AB 5 and AB 1183, CMS rejected the rate reductions set forth in AB 5 and AB 1183, because California could not demonstrate that the rate reductions mandated by AB 5 and AB 1183 would permit California to meet the access and quality of care provisions of the Medicaid Program. No. 09-958, Gov't Pet. Br. App. 1a-4a.

Pharmacists and pharmacies such as the members of the Associations providing this *amicus* brief are on the front line of providing healthcare services to Medicaid beneficiaries. They serve those who are "most impoverished and who -- because of their physical characteristics [are] often least able to overcome the effects of poverty." *Swiker v. Hogan*, 457 U.S. 569, 590 (1982). "These people are the most needy in the country and it is appropriate for medical care costs to be met, first, for these people." *Id.* (internal quotation marks and citations omitted). It is in the public interest that those with the resources, the incentive, and who suffer an injury that is concrete, particular, and redressable, such as providers, have a means by which they can seek to assure that States do not pass State laws which conflict with federal law intended to protect "the most needy in the country." *Id.* at 572.

A recent study of Oregon's Medicaid Program further evidences the importance of the Medicaid Program. The Study found that as compared to people without insurance, individuals on Medicaid received better health care, prescription drugs and physician visits. Finklestein et al., The Oregon Health Study Group, *The Oregon Health Insurance Experiment: Evidence from the First Year* at 5

(2011), *available at* http://www.nber.orgs.papers/w17190. Although there was a short-term cost to providing care to additional beneficiaries, the long-term effects of access to Medicaid Programs seem to be a healthier, more productive population, which may have less need for costly medical services in the future. *Id.* at 7.

Despite the proven benefits of Medicaid Programs on beneficiaries long-term health, States continually jeopardize the Medicaid Program by reducing providers' rates to unsustainable levels. For example, in spite of the steep reductions envisioned by AB 5 and AB 1183, California planned, contrary to the plain language of the Medicaid regulations, to implement the payment reductions mandated by AB 5 and AB 1183 absent CMS approval. 42 C.F.R. § 430.12(c). Thus, absent a cause of action pursuant to the Supremacy Clause, a State law which CMS subsequently found conflicted with federal law because it failed to assure "access" and "quality of care" for Medicaid beneficiaries would have been in effect for over two years with the consummate loss of "access," "quality of care," and degradation of health among some of the country's most vulnerable. The cause of action the State claims does not exist provided the means for assuring that the improper rate reductions did not happen.

IV. This Court Has Distinguished Between Causes of Action Under the United States Constitution and Those Claims Brought Under 42 U.S.C. § 1983

Petitioners contend that individuals cannot invoke the Supremacy Clause when State law conflicts with federal law unless the statute provides a private cause of action enforceable under 42 U.S.C. § 1983. *See* No. 09-1158, Pet. Br. at 20-26. This argument is not consistent with the different reasoning applied by this Court in analyzing preemption claims under the Supremacy Clause and claims brought under § 1983. Section 1983 provides a cause of action for "the deprivation of any rights, privileges, or immunities secured by the Constitution and laws" by a person acting under color of State law. In *Cort v. Ash*, this Court enunciated a four-part test to determine whether Congress intended to imply a right to sue directly under a federal statute. In general, a plaintiff asserting such a right is required to show that (1) membership in the class for whose benefit the statute was enacted, (2) evidence of Congress' intent to confer a private remedy, (3) that a right to sue would be consistent with the statutory purpose, and (4) that the cause of action is not one traditionally relegated to the States to a degree that implying a right to sue would be inappropriate. 422 U.S. 66, 78-79. Under this doctrine, a plaintiff must show that Congress intended to grant both a private right and a private remedy. *See Alexander v. Sandoval*, 532 U.S. 275, 286 (2001).

While cases brought under 42 U.S.C. § 1983 are required to meet the Court's stringent "rights"

requirement, this Court enunciated a different analysis for claims alleging a constitutional violation. In *Verizon, supra,* this Court made an important distinction between claims brought under 42 U.S.C. § 1983 for violations of federal statutes or laws and preemption claims brought under the Supremacy Clause. In *Verizon* this Court found that the existence of a statutory cause of action was not relevant to court access. Instead, this Court emphasized in *Verizon* the absence of evidence that Congress intended to foreclose judicial review in cases alleging preemption under the Supremacy Clause. *Id.* at 643-644. The less stringent analysis for cases involving conflicts between federal and State laws adopted in *Verizon* is entirely consistent with federal supremacy and rule of law mandates.

Claims which rest on the Supremacy Clause address, through injunctive relief, a systematic conflict between State and federal laws thereby supporting the federal structure. In contrast, claims brought under 42 U.S.C. § 1983 provide damages to address ad hoc violations of federal law by State officials in executing their official duties. Plaintiffs who suffer ad hoc violations generally do not have standing for prospective injunctive relief because the violations are not ongoing. Conversely, preemption claims under the Supremacy Clause may only be brought for an ongoing conflict between federal law and State law. Thus, the Supremacy Clause creates a private cause of action solely for injunctive relief that addresses systemic violations of law by the States whereas the more appropriate function of § 1983 is to provide damages to address ad hoc violations of law by State officials.

V. Petitioners' Fiscal Arguments Are Not a Basis to Deny a Cause of Action Under the Supremacy Clause

States argue that they will be injured or somehow harmed if they cannot effectively fiscally manage their State Medicaid Programs. This is a red herring. Requiring a State not to enact legislation which conflicts with federal law even when administering its Medicaid Program is not an undue hardship. States voluntarily participate in Medicaid and voluntarily offer pharmacy services. It is disingenuous for States to say they want the fruits of participation in a federally financed program but can pass State laws which conflict with the rules Congress has imposed on that participation.[4] Moreover, as this Court has explained:

> [T]he fiscal consequences to state treasuries in these cases were the necessary result of compliance with decrees which by their terms were prospective in nature. State officials, in order to shape their official conduct to the mandate of the Court's decrees, would more likely have to spend money from the state treasury than if they had been left free to pursue their previous course of conduct. Such an ancillary effect on the state treasury is a permissible and often an inevitable

---

[4] More broadly stated, the States want the benefit of joining the Union, without the risk that a person within the State would successfully seek to enforce that Supremacy of federal law.

> consequence of the principle announced in *Ex parte Young*.

Edelman v. Jordan, 415 U.S. 651, 667-68 (1974).

Depriving individuals of a cause of action to challenge a State law that conflicts with federal law when that law causes them a "concrete, particular, and redressable" injury would strip individuals of the ability to "challenge a law as enacted in contravention of constitutional principles of federalism." *Bond*, slip op. at 11. That such a challenge may affect a State treasury is simply irrelevant.

VI. This Court Should Not Treat Laws Enacted Pursuant to the Spending Clause Differently from Other Federal Laws

While the courts of appeals have uniformly applied *Verizon* in Spending Clause cases, some have claimed that Spending Clause statutes are to be treated differently from other laws. This argument is based on a contract analogy introduced in *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1, 17 (1981) suggesting that Spending Clause statutes function in a manner similar to contracts between the federal and State governments in that federal funds are conditioned on compliance with federal mandates.

This argument has no basis in the text of the Constitution. The Supremacy Clause applies to all federal statutes; nothing in the text of the Constitution limits the scope of the Supremacy Clause for statutes enacted under the Spending Clause. Like all other statutes, laws enacted

pursuant to Congress's power under the Spending Clause are "supreme federal law" that trump State and local laws. This makes perfect sense because federal law is "'the supreme Law of the Land' even absent an express statement by Congress." *Pliva*, slip. op. at 14.

Pennhurst used the contract analogy in concluding that "if Congress intends to impose a condition on the grant of federal moneys, it must do so unambiguously." *Pennhurst*, 451 U.S. at 17. This principle has been extended to apply to questions of statutory interpretation that affect the amount of the State's financial responsibilities, so that a State must have "clear notice regarding the liability" imposed by the statute. *Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy*, 548 U.S. 291, 296 (2006). Permitting private parties to bring a cause of action under the Supremacy Clause would not impose a new condition upon States receiving Medicaid funds. First, the Medicaid statute clearly conditions the grant of federal funds on the State complying with the Medicaid Act's requirements, including the requirements set forth in Section 30(A). Second, the judicial remedy for federal law preemption is an injunction against the ongoing violation. This remedy is standard, and therefore, States have historically been on notice that Courts will enjoin State laws which conflict with federal law.

In sum, assertions based on contract law are not only dubious, but also are irrelevant to preemption claims. Preemption is not based on assent to contract terms but rather on the States' affirmation of the Constitution making federal law supreme. Numerous scholars, as well as courts of appeals,

have pointed out that the applicable cause of action to bring preemption claims is inherent in the Supremacy Clause, just as courts have recognized causes of action to enforce other constitutional provisions. *See, e.g.*, *Planned Parenthood of Houston & Southeast Texas v. Sanchez*, 403 F.3d 324, 333 (5th Cir. 2005); *Local Union No. 12004, United Steelworkers of Am. v. Massachusetts*, 377 F.3d 64, 75 (1st Cir. 2004); *see also Sloss*, 89 Iowa L. Rev. at 363. As a result, no additional cause of action is needed in any statute to bring a Supremacy Clause preemption claim, no matter whether its source of congressional authority is the Spending Clause, the Commerce Clause, or any other Constitutional Clause.

CONCLUSION

The judgments below should be affirmed.

Respectfully submitted,

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RECORD AND BRIEFS

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TOBY DOUGLAS, Director of the Department of Health Care Services, State Of California,

v.

INDEPENDENT LIVING CENTER OF SOUTHERN CALIFORNIA, INC., A Nonprofit Corporation, et al.,

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TOBY DOUGLAS, Director of the Department of Health Care Services, State Of California, et al.,

v.

CALIFORNIA PHARMACISTS ASSOCIATION, et al.,

TOBY DOUGLAS, Director of the Department of Health Care Services, State Of California,

v.

SANTA ROSA MEMORIAL HOSPITAL, et al.,

On Writs of Certiorari to the United States Court of Appeals for the Ninth Circuit

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BRIEF OF NATIONAL GOVERNORS ASSOCIATION, NATIONAL CONFERENCE OF STATE LEGISLATURES, COUNCIL OF STATE GOVERNMENTS, NATIONAL ASSOCIATION OF COUNTIES, INTERNATIONAL CITY/COUNTY MANAGEMENT ASSOCIATION, AND UNITED STATES CONFERENCE OF MAYORS AS *AMICI CURIAE* IN SUPPORT OF PETITIONER

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QUESTION PRESENTED

These *amici* will address only the following question of law:

Whether the Supremacy Clause supplies a cause of action to sue in federal court even where the underlying federal law creates neither a federal right nor a defense.

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INTEREST OF *AMICI CURIAE*[1]

Amici — the National Governors Association, the National Conference of State Legislatures, the Council of State Governments, the National Association of Counties, the International City/County Management Association, and the United States Conference of Mayors — are national organizations whose members include State, county, and municipal elected and appointed officials from across the United States. These organizations regularly file *amicus* briefs in cases that, like this one, concern federalism and raise pre-emption challenges.

In this case, the Court will decide whether the Ninth Circuit misconstrued the Supremacy Clause and expanded the scope of pre-emption under which private parties without federal rights or defenses may seek legal and equitable relief to enforce their own notions of what federal statutes require of States.

If the Ninth Circuit's opinion stands, certain discretionary decisions may be subject to lawsuit or frozen by injunction by any private party with standing that believes a State or locality has misread federal law.

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[1] No counsel for a party authored this brief in whole or in part, and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. Besides *amici curiae* or their counsel, no party has made a monetary contribution to this brief's preparation and submission. The parties have consented to the filing of this brief.

Not only would this impose new costs in dollars and time, such a free-standing cause of action would have a chilling effect on new and creative State and local solutions to dynamic fiscal and policy circumstances. For these reasons, the *amici* have a substantial interest in this case and a unique perspective on its proper resolution.

INTRODUCTION AND SUMMARY OF ARGUMENT

It is undisputed that Respondents in this case have no right of action under any federal statute. It is also undisputed that Respondents are not subject to any State enforcement action to which federal law might serve as a defense. The Court of Appeals nonetheless held that the Supremacy Clause itself supplies a cause of action, permitting plaintiffs to bring suit in federal court for pre-emption of State law in any case where they have standing. We submit that is in error. Understood in light of its history and subsequent interpretation, the Supremacy Clause is a priority rule that makes clear that, whenever a conflict between State law and federal law arises in the course of litigation, courts must give precedence to the federal law. The Supremacy Clause is not a roving commission to allow plaintiffs to seek judicial correction of perceived conflicts between State and federal law, where they personally have neither a right nor a defense under federal law.

ARGUMENT

I. THE HISTORY OF THE SUPREMACY CLAUSE SHOWS THAT IT DOES NOT GRANT RESPONDENTS A CAUSE OF ACTION WHERE FEDERAL LAW DOES NOT CREATE A RIGHT.

The Supremacy Clause is a solution to the inherent potential conflict in a two-tiered federal system in which the several States and the general government have overlapping authority to legislate in certain areas. As debates in the Philadelphia

Convention reveal, the Supremacy Clause was crafted as an alternative to James Madison's favored solution of a congressional "negative" on State laws, and was based on the Americans' prior experience of a kind of federalism within the British imperial system. *See* Mary Sarah Bilder, *The Transatlantic Constitution: Colonial Legal Culture and the Empire* 11 (2004). That system allowed the colonial legislatures substantial powers of local self-government within boundaries set by British law.

The British imperial system — dubbed by historians the "transatlantic constitution" — employed two basic procedural mechanisms for ensuring that colonial law did not offend British law. Some, but not all, colonies were required to send copies of enacted statutes to London for review by the Lords of the Committee for Trade and Plantations (commonly called the "Board of Trade"), which had the power to annul colonial laws deemed repugnant to British law. *Id.* at 54-57. This was the model for Madison's "negative." In addition, parties in ordinary litigation in colonial courts could appeal to London — to the Privy Council's Committee for Hearing Appeals from the Plantations, which acted in an essentially judicial capacity — in cases of claimed repugnancy between colonial and British law. *Id.* at 73-90, 125-26. This became the model for the Supremacy Clause.

A. The Supremacy Clause's Antecedents In The Colonial Charters Did Not Recognize Causes Of Action Where English Law Did Not Create A Right.

The concerns reflected in the Supremacy Clause were not new at the time of the Constitutional

Convention. Long before the American colonies declared their independence, the question of how to ensure consistency between a supreme central authority and peripheral legislatures was a concern of British imperial administrators. Their answers to that question are reflected in the colonial charters granted in the seventeenth and early eighteenth centuries.

1. The Colonies were required to legislate consistently with English law.

The transatlantic constitution permitted substantial local self-government, thus contemplating a certain amount of divergence from British legal norms. At the same time, however, colonial charters required adherence to fundamental British law and forbade the enactment and enforcement of laws "repugnant" to British law. The Second Charter of Virginia, for example, adopted in 1609, granted the colonial Council "full and absolute Power and Authority to . . . govern . . . according to such Orders, Ordinances, Constitutions, Directions, and Instructions, as by our said Council as aforesaid, shall be established[.]" *See* Francis Newton Thorpe, *The Federal and State Constitutions Colonial Charters, and Other Organic Laws of the States, Territories, and Colonies Now or Heretofore Forming the United States of America Compiled and Edited Under the Act of Congress of June 30, 1906* 3801 (1909) ("*Federal & State Constitutions*").[2] That

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[2] This charter, and the other colonial charters cited herein, is also available online through the Avalon Project at the Yale law

authority, however, came with a proviso: It would hold on condition that "the said Statutes, Ordinances and Proceedings as near as conveniently may be, be *agreeable* to the Laws, Statutes, Government, and Policy of this our Realm of England." *Id.* (emphasis added).[3]

Later colonial charters added a degree of clarity to the requirement that colonial law be "agreeable" to that of England. In most charters, that requirement evolved into the rule that colonial governments could not contradict English law. The Third Charter of Virginia, for example, required that Virginia's laws "*be not contrary to* the Laws and Statutes of this our Realm of England[.]" *Id.* at 3806 (emphasis added). The 1629 Massachusetts Bay Charter granted power to legislate so long as the laws "be not contrarie or repugnant" to English law. *See id.* at 1853.[4] The 1662 Connecticut charter granted authority to enact legislation "not Contrary to" English law, *id.* at 533; likewise the 1732 Georgia Charter required that colonial laws "be reasonable and not contrary or repugnant to the laws or statutes" of England, *id.* at

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library. *See* http://avalon.law.yale.edu/subject_menus/statech.asp.

[3] "Agreeable," as defined by Samuel Johnson, meant "[s]uitable to; consistent with; conformable to." I Samuel Johnson, *A Dictionary of the English Language* (6th ed. 1785) (unpaginated) ("Johnson").

[4] An informative discussion of the development of Massachusetts and other New England colonial charters can be found in David A. Weir, *Early New England: A Covenanted Society* (2005).

770.[5] *See also, e.g., id.* at 3215 (1663 Rhode Island Charter ("not contrary and repugnant unto, butt, as neare as may bee, agreeable to the lawes of this our realme of England, considering the nature and constitutions of the place and people there")); *id.* at 2765 (1665 Carolina Charter ("reasonable, and not repugnant or contrary, but as near as may be, agreeable to the laws and statutes of this our kingdom of England")). These provisos foreshadowed our modern idea of conflict pre-emption.

In contrast to the later Supremacy Clause, not all Acts of Parliament were superior to colonial law. In general, it was thought that the "plantations" were subject to some or all of the common law that had been in effect at the time of settlement. Subsequent Acts of Parliament applied to the "plantations" only if they were expressly mentioned or if the colonies voluntarily adopted them. *See* Bilder, *The Transatlantic Constitution* at 37-39.

2. Enforcement of consistency with English law did not include causes of action for colonists who did not have legal rights.

Enforcement of consistency between colonial and English law was the responsibility of the English Privy Council. The Privy Council had both

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[5] Johnson defined "contrary" as "[o]pposite; contradictory; not simply different, or not alike, but repugnant, so that one destroys or obstructs the other," or as "[i]nconsistent; disagreeing." I Johnson. "Repugnant" meant "[c]ontrary; opposite; inconsistent." II Johnson.

administrative and legal means at its disposal for that task. *See* Phillip Hamburger, *Law and Judicial Duty* 261 (2008) ("The Privy Council served as a judicial court to hear appeals from colonial courts, but it also oversaw the Empire[.]").

The principal administrative method of enforcing consistency with English law was direct review of colonial statutes, followed by approval or disallowance. Originally applied only to Royal colonies, by 1700 most colonial charters had adopted the requirement that the colonial assemblies send their laws to England for such review. *See* Bilder, *The Transatlantic Constitution* at 54-56. [6]

Review of colonial statutes from 1696 through Independence was conducted by the Lords of Trade and Plantations, usually called the Board of Trade, which advised the Privy Council on statutes sent for review. Elmer Beecher Russell, *The Review of American Colonial Legislation by the King in Council* 44 (1915). The Board of Trade would sometimes focus on colonial statutes brought to its attention by petitions from parties who claimed to be injured by them, *id.* at 50, and it gradually adopted quasi-judicial procedures for its hearings, *id.* at 51-52. But the Board of Trade was not a court; its proceedings were not strictly judicial in nature; and its

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[6] Rhode Island lacked such a provision. The ultimate English authority over Rhode Island, in fact, was the threat that its charter would be revoked. To avert that outcome, the colonial legislature put considerable effort into ensuring that its laws would be consistent with those in England (and convincing English authorities of that consistency). Bilder, *The Transatlantic Constitution* at 57-69.

proceedings were not triggered by anything like a legal complaint and cause of action. Rather, the Board's authority was essentially political and administrative. Hamburger, *Law and Judicial Duty* at 261 (referring to the disallowment of colonial legislation as an "executive" function). Significantly (and similar to Madison's later proposal for a "negative" at the Convention), the Board was charged not only with the job of determining whether colonial legislation was consistent with English law, but whether it was expedient and consistent with the Empire as a whole. Russell, *Review of American Colonial Legislation* at 109. That was necessarily a matter not just of law, but of policy. *See, e.g., id.* at 118 (discussing the Board's role in preventing the colonies from competing with English industries); 120-21 (Board's role in regulating colonial paper currency).

Other charters provided for judicial process to ensure conformity of colonial to British law. This took the form of a right for litigants in colonial cases to appeal adverse court judgments to the Privy Council, which would protect the rights or defenses that English law conferred. The 1622 Gorges Charter, for example, provided that when the Maine colonial government was in "default" of its obligation to conform to English law, "it shall be lawful for any of the aggrieved inhabitants and planters . . . to appeal" to the Council of New England, based in Devonshire. *Federal & State Constitutions* at 1624. King Charles II's 1676 Grant of New England to the Duke of York was even more explicit. That charter, just after familiar language requiring that colonial laws "be not contrary to, but as near as conveniently may be, agreeable" to English law, added a provision

"saving and reserving to us . . . the receiving, hearing, and determining of the appeal and appeals of all or any person or persons of, in or belonging to the territories or islands aforesaid, in or touching any judgment or sentence to be there made or given." *Id.* at 2591-92. The 1681 Pennsylvania Charter was similar: It required that colonial laws "bee consonant to reason, and bee not repugnant or contrarie, but as neare as conveniently may bee agreeable to the Lawes and Statutes, and rights of this Our Kingdome of England," and then reserved to the Crown "the receiving, heareing, and determining of the appeale and appeales of all or any Person or Persons, of, in, or belonging to the Territories aforesaid, or touching any Judgement to bee there made or given." *Id.* at 3038. Some sources indicate that the right to appeal to the Privy Council was considered an inherent right of the King's subjects, even without express mention in the charter, Arthur M. Schlesinger, *Colonial Appeals to the Privy Council*, 28 Poli. Sci. Q. 279, 288 (1913), but some colonies contested the right of appeal, contending that it, along with other elements of royal prerogative, had been vested in colonial authorities by the charter. *Id.* at 293-97; *Bilder, The Transatlantic Constitution* at 73-90.

In contrast to direct review of colonial statutes by the Board of Trade, appeals were conducted by the Privy Council's Committee for Appeals, which had a judicial character. Hamburger, *Law and Judicial Duty* at 261 (referring to the hearing of appeals from colonial courts as an exercise of the Privy Council's "judicial capacity"); *see also* Bilder, *The Transatlantic Constitution* at 74 (discussing the formalization of appellate practice in the 1690s). If

the colonial court granted leave, review in the Committee was by appeal; if not, review was by petition. Schlesinger, *Colonial Appeals to the Privy Council*, 28 Poli. Sci. Q. at 437. Litigation before the Committee was conducted by members of the bar, based on the formal record on appeal, subject to ordinary legal rules, and resulted in a legally binding judgment of either affirmance or reversal followed by a remand to the colonial court. *See* Bilder, *The Transatlantic Constitution* at 122-28; Schlesinger, *Colonial Appeals to the Privy Council*, 28 Poli. Sci. Q. at 437-38.

Appeals were not conceived as arising under the transatlantic constitution's "repugnancy" principle, for mere repugnancy of colonial to English law did not supply the underlying cause of action. Rather, the appeals arose in ordinary cases, which were based on ordinary causes of action implicating personal rights at admiralty, common law, or equity. "Repugnancy" served instead as an argument on the merits. *See id.* at 85-86. In other cases, English law was a defense to application of "repugnant" colonial law. *See* Joseph Henry Smith, *Appeals to the Privy Council from the American Plantations* 561 (1950).

For example, historian Arthur Schlesinger Sr. identified three Privy Council appeals of the greatest legal significance for the validity of colonial statutes: *Winthrop v. Lechmere*, *Phillips v. Savage*, and *Clark v. Tousey*. Each implicated the validity of colonial statutes, and each arose from a dispute between an heir who stood to gain from the colonial intestacy statutes and an heir who stood to receive more under the English common law rule. Schlesinger, *Colonial*

Appeals to the Privy Council, 28 Poli. Sci. Q. at 440-45.

In Rhode Island, the first successful private-party appeal from Rhode Island to the Privy Council involved a land dispute that ultimately turned on whether a colonial law constituting the colonial Assembly as a court of equity was repugnant to British law, which confined equity to the prerogative courts of the Crown. Bilder, *The Transatlantic Constitution* at 80-82. This resolved an important and contested question of the respective authority of colonial and royal courts, *id.* at 79, but it arose in an ordinary case about ownership of land.

Another illustrative example from Rhode Island was the litigation brought by James MacSparran, a clergyman of the Church of England, to clear title to lands set aside for support of an "orthodox" minister. The colonial court concluded that this meant, in context, the Congregationalist claimant. MacSparran appealed to the Privy Council on the ground that only a minister of the Church of England could be deemed "orthodox" under English law. The Privy Council's decision against MacSparran was an important decision restricting the reach of the established church in the colonies. *Id.* at 159-167. But despite its broad significance, the cause of action was MacSparran's mundane allegation of trespass against the lessee of a rival claimant. *Id.* at 160. In the absence of an established common law cause of action, there could have been no case, and there could have been no appeal. Neither the importance of the question nor the allegation of "repugnance" in the abstract would have sufficed.

Some charters, in short, subjected colonial laws to an English veto. Although colonists could (and did) petition English authorities for the invalidation of colonial statutes, such petitions were fundamentally political and administrative in nature, rather than judicial in the modern sense. Other charters took a judicial approach, permitting appeals to English tribunals of colonial judgments and sentences in the course of ordinary litigation. It therefore appears that although the colonies were prohibited to enact legislation conflicting with English law, that prohibition did not alter the principle that litigants can go to court for judicial relief only if they satisfy the ordinary requirements of a cause of action in law or equity.

B. The Framers Did Not Intend The Supremacy Clause To Create A Cause Of Action Where There Is No Federal Right To Enforce.

The questions of imperial administration that appeared during the colonial period surfaced once again in designing a federal union. The Framers, in their effort to resolve the problems that plagued the United States under the Articles of Confederation, had to decide how to ensure that the States would exercise their sovereignty consistently with the Union and the federal Constitution. Both forms of imperial review described above — direct review and judicial appeal — were urged at the Convention, with explicit reference to prior British imperial practice. The Supremacy Clause's history at the Convention indicates that it was adopted as the less intrusive remedy from the point of view of the States.

Early explications of the Supremacy Clause confirm that view.

1. The records of the Constitutional Convention do not indicate that a free-standing cause of action based on the Supremacy Clause was contemplated where federal law does not create a right.

For the first half of the Constitutional Convention, it was assumed that the supremacy of federal law would be enforced by Congress on analogy to the post-enactment review of colonial statutes by the Board of Trade. The Virginia Plan vested the National Legislature with power "to negative all laws passed by the several States, contravening in the opinion of the National Legislature the articles of Union." I *The Records of the Federal Convention of 1787* 21 (Max Farrand ed., rev'd ed. 1966) ("Farrand"). Charles Pinckney and James Madison sought to expand the negative to allow invalidation of any State law the Congress "shd. judge to be improper," thus permitting Congress to invalidate State laws on the basis of policy as well as unconstitutionality. *Id.* at 164. Both supporters and opponents of the negative drew analogies to review of colonial statutes by the Board of Trade. *See id.* (C. Pinckney) ("under the British Govt. the negative of the Crown had been found beneficial, and the States are more one nation now, than the Colonies were then."); *id.* at 168 (Madison) ("This was the practice in Royal Colonies before the Revolution"); *id.* at 337 (Lansing) (the proposed "Negative would be more injurious than that of Great Britain heretofore was"); II Farrand at 28 (Madison)

(the "utility" of the negative "is sufficiently displayed in the British System").

The Framers agreed that the Union would require some sort of federal check on State legislation inconsistent with the Constitution. The debate centered on whether that check would be best exercised on a blanket basis by Congress or by courts when the issue arose in ordinary litigation. On July 17, 1787, James Madison, the congressional negative's most important supporter, called the "power of negativing the improper laws of the States" the "most mild & certain means of preserving the harmony of the system," reminding his listeners of the "utility" of the device in the prior "British System." II Farrand at 28. Other delegates were skeptical or even hostile to this idea. Luther Martin called the negative "improper & inadmissible," on the ground that State laws should not have to be "sent up to the Genl. Legislature before they shall be permitted to operate[.]" II Farrand at 27. Even nationalist Gouvernour Morris declared that the negative would "likely be terrible to the States." II Farrand at 27. Future Chief Justice John Rutledge declared that the presence of the negative "would damn and ought to damn the Constitution." II Farrand at 391. It would bind the States "hand and foot" and make "mere corporations of them." *Id.*

Most significantly, Morris and Roger Sherman argued that a negative was unnecessary because courts would not treat a State law as valid if it came into conflict with the Constitution. *Id.* at 27, 28. Morris explained that any law that "ought to be negatived" would be "set aside" in court anyway or else "repealed by a Nationl. law." *Id.* at 28.

Sherman added that the argument for the negative rested on the false premise that State laws inconsistent with the Constitution would be valid otherwise. *Id.* at 23. In light of the familiarity to the Framers of the practice of appeals under the prior British transatlantic system, this was not a surprising reaction. Madison did not disagree, but worried that State courts could not be relied on to disregard invalid legislation as his opponents supposed. *Id.* at 27. Notwithstanding Madison's concerns, the Convention voted down the negative by seven States to three. *Id.* at 28.

It was at that point that the Convention substituted the language that, with later changes, eventually became the Supremacy Clause. That proposal passed unanimously and without recorded discussion. *Id.* at 28-29. Luther Martin, who offered the successful motion, wrote that he proposed the Supremacy Clause "in substitution of" the negative. III Farrand at 286.[7] The unmistakeable inference is that the Convention resolved the debate over how to enforce the supremacy of federal law by reliance on the judicial duty to apply federal law in cases of

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[7] The July 17 motion borrowed the language of ¶6 of the New Jersey Plan. *See* I Farrand at 245 ("Resd. that all Acts of the U. States in Congs. made by virtue & in pursuance of the powers hereby & by the articles of confederation vested in them . . . shall be the supreme law of the respective states so far forth as those Acts . . . shall relate to the said States or their Citizens, and that the Judiciary of the several States shall be bound thereby in their decisions, any thing in the respective laws of the Individual States to the contrary nonwithstanding[.]"). After subsequent changes, described below, Martin declared the final version "worse than useless." III Farrand at 287.

conflict rather than by post-enactment inspection and political review.

It is important to note that the Convention did not invest courts with a special power to enforce federal supremacy, but evidently contemplated that conflicts would arise, as they had under the prior British system, in the ordinary course of litigation. The courts' power was not conceived as the enforcement of federal mandates (although some federal statutes surely could be coercively enforced), but simply the decision as to which laws, State or federal, would prevail, and which would be void.

In its original form, as adopted on July 17, the Supremacy Clause relied on "the Judiciaries of the several States" to enforce the supremacy of federal law, presumably with appeal to the Supreme Court. II Farrand at 29. At this point, there had been no provision for creation of the lower federal courts. The July 17 version thus closely resembled the prior system of Privy Council appeals, with State courts playing the role of colonial courts, and the United States Supreme Court playing the role of the Privy Council.

The Clause underwent significant substantive revision, first by the Committee on Detail and later by the Committee on Style. According to Edmund Randolph's notes from meetings of the Committee on Detail, the Committee considered a version of the Clause stating that "All laws of a particular state, repugnant hereto, shall be void." II Farrand at 144. The draft further provided that the "decision thereon" would be "vested in the supreme judiciary." *Id.* The language of "repugnancy" harkened back to prerevolutionary colonial charters, and the term

"void" indicated the essentially negative nature of contemplated relief. The Committee, however, rejected this draft in favor of language similar to the July 17 version, but vesting decisions in "the judges in the several states," rather than "the Judiciaries of the several States," a change that entailed enforcement of the supremacy of federal law by inferior federal courts as well as by State courts. *Id.* at 183.[8] This presumably mitigated Madison's concern about reliance on State courts. A change on the floor on August 23, 1787 expanded the scope of federal supremacy beyond "Acts of the Legislature of the United States" to include *all* federal law, including the Constitution itself. *Id.* at 381-82. Lastly, the Committee on Style broadened its language to include future treaties and completed it with the "supreme law of the land" language we are familiar with today. *Id.* at 603.

In the final days of the Convention, Charles Pinckney sought to revive the congressional negative, this time with the proviso that it could be exercised only by a two-thirds vote of both houses of Congress. *Id.* at 390. Some delegates supported it. James Wilson, for example, thought that "[t]he firmness of Judges is not, of itself, sufficient" to ensure federal supremacy. *Id.* at 391. Sherman and Hugh Williamson, though, "thought it unnecessary" in light of federal legal supremacy. *Id.* at 390-91.

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[8] By changing the language from "Judiciaries" to "judges," the Committee on Detail also made clear that judges, not juries, would decide questions of pre-emption and constitutionality. *See* Forrest McDonald, *Novus Ordo Seclorum: The Intellectual Origins of the Constitution* 255 (1985).

After a short debate, this version of the negative failed as well. *Id.* at 391.

Wilson's indirect reference to the Supremacy Clause virtually sums up the Convention's debate. That courts would have a duty to "set aside" State laws inconsistent with the Constitution does not appear to have been in doubt. As shown by these debates, the Convention rejected the negative at least in part on the belief that courts would have a duty to accomplish the same end, in a less intrusive manner.

2. Early interpretations do not indicate that the Supremacy Clause was regarded as creating a free-standing cause of action where there is no federal right to be enforced.

Two essays of *The Federalist*, numbers 33 (Alexander Hamilton) and 44 (James Madison), analyze of the meaning of the Supremacy Clause. *The Federalist* (Clinton Rossiter ed., 1961). Neither Hamilton nor Madison specifically addressed any charge that the Supremacy Clause by itself could be used as a basis to hale States into court on an abstract pre-emption theory where there is no federal right to be enforced — though that argument surely would have been made by Anti-federalists if they had considered it possible. Instead, wrote Hamilton: "If a number of political societies enter into a larger political society, the laws which the latter may enact, pursuant to the powers intrusted to it by its constitution, must necessarily be supreme over those societies and the individuals of whom they are composed." *Id.* No. 33, at 204. Otherwise, the

larger political association would "be a mere treaty . . . and not a government, which is only another word for political power and supremacy." *Id.* (emphasis omitted). For that reason, the Supremacy Clause *"only declares a truth which flows immediately and necessarily from the institution of a federal government."* *Id.* at 205 (emphasis added).

Madison took a similar view. Because many of the existing State constitutions reserved to themselves the powers not granted to the United States under the Articles of Confederation (or, indeed, "d[id] not even expressly and fully recognize the existing powers of the Confederacy"), it was necessary to vest supreme authority in Congress. *Id.* No. 44, at 286-87. If the Constitution had (hypothetically) contained a savings clause instead, Madison observed, "the new Congress would have been reduced to the same impotent condition with their predecessors," *id.* at 286, and federal laws might even have had different application in different States, *id.* at 287.

Joseph Story, writing decades later, reached much the same conclusion. Seconding Hamilton, Story wrote that the Supremacy Clause "only declares a truth, which flows immediately, and necessarily from the institution of a national government." III Joseph Story, *Commentaries on the Constitution of the United States* § 1831, p. 694 (1833) ("Story"). "The propriety" of the Clause "would seem to result from the very nature of the constitution." *Id.* at 693. Its principle therefore would have been "necessarily implied" if it had not been in the text, *id.*, but it was "introduced from abundant caution, to make its obligation more

strongly felt by the state judges." *Id.* at § 1833, p. 697.

In explaining "Rules of Interpretation" of the Constitution, Story wrote: "Whenever the question arises, as to whom obedience is due," *i.e.*, to a State or to the federal government, "it is to be judicially settled" by the Supremacy Clause, "and being settled, it regulates, at once, the rights and duties of all the citizens." I Story at § 414, p. 397. Thus, where federal law creates a right or a defense, there is a right to judicial relief, and the Supremacy Clause establishes the rule of decision. But the Supremacy Clause is not a cause of action otherwise.

3. Historical evidence therefore leads to the inference that the Supremacy Clause was not intended to create a free-standing cause of action absent a federal right.

The historical evidence makes it deeply improbable that the Supremacy Clause of its own force was understood to create a federal cause of action for pre-emption even when no federal rights or defenses are at issue. Indeed, in light of the role the Supremacy Clause served at the Convention — a consensus measure when the Framers decided against comprehensive federal review of State legislation — interpreting the Clause as creating a cause of action of that sort would be quite a stretch. The Clause, after all, contemplated the resolution of State-federal legal conflicts during ordinary litigation as a substitute for a highly intrusive review of State legislation. To treat it as authorizing private lawsuits in *all* cases of arguable federal pre-

emption would replicate much of the intrusion the opponents of the negative found troubling, and that the Supremacy Clause was intended to avoid.

II. THIS COURT HAS NOT INTERPRETED THE SUPREMACY CLAUSE AS CREATING A FREE-STANDING CAUSE OF ACTION ABSENT A FEDERAL RIGHT.

The Supreme Court's past pronouncements on the Supremacy Clause are consistent with this historical understanding. Briefly, they establish that the Supremacy Clause provides a rule for resolution of conflicts between State and federal law when they arise in the course of ordinary litigation, but it does not create the free-standing cause of action contemplated by Respondents.

A. Respondents' Cause Of Action Is Inconsistent With Existing Methods Of Vindicating Federal Rights And Defenses.

This Court has explained that the Supremacy Clause "is not a source of *any* federal rights[.]" *Chapman v. Houston Welfare Rights Org.*, 441 U.S. 600, 613 (1979) (emphasis added); *accord Dennis v. Higgins*, 498 U.S. 439, 450 (1991) (contrasting the Supremacy Clause with the Commerce Clause). Rather, the Clause "'secure[s]' federal rights by according them priority whenever they come in conflict with state law." *Chapman*, 441 U.S. at 613. The "right," in other words, must derive either from some other provision of the Constitution itself or from federal statute. This echoes Justice Story's view that the Supremacy Clause "settle[s]" the question of federal supremacy "[w]henever [it] arises." I Story at § 414, p. 397. The question is *how*

conflicts between federal rights and State laws, resolvable through the Supremacy Clause, actually arise. Caselaw shows that absent a federal right or defense, the Supremacy Clause of its own force does not provide a cause of action.

As a general matter, federal rights "come into conflict with state law" in the context either of State enforcement of pre-empted law or the enforcement of federal rights. For example, it is elementary that when a State applies its law (including tort law) in a suit against a federally regulated entity, the defendant is free to raise federal pre-emption as an affirmative defense. *See, e.g.*, *Williamson v. Mazda Motor of Am., Inc.*, 131 S. Ct. 1131 (2011) (addressing alleged pre-emption of State tort law by Federal Motor Vehicle Safety Standards); *Geier v. American Honda Motor Co., Inc.*, 529 U.S. 861 (2000) (same). Likewise, when a federal statute such as 42 U.S.C. § 1983 provides a private cause of action for vindication of federal rights, parties holding those rights can go to court to seek affirmative relief, including injunctive or declaratory relief against pre-empted State law. *See, e.g.*, *Golden State Transit Corp. v. City of Los Angeles*, 493 U.S. 103 (1989). It is undisputed in this case that Respondents have no federal rights under the statute, so these uses of the Supremacy Clause do not pertain.

Under carefully defined circumstances, parties have a right in equity to assert an anticipatory defense against the enforcement of a pre-empted State law, and to obtain relief in the form of a writ of injunction or prohibition. *See, e.g.*, *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96 n.14 (1983) (recognizing federal court jurisdiction over a plaintiff's suit in

equity to enjoin a State regulation that infringes federal rights); *Ex parte Young*, 209 U.S. 123, 160-62 (1908). As Justice Kennedy has recently explained, the "negative injunction" available in such cases is "nothing more than the pre-emptive assertion in equity of a defense that would otherwise have been available in the State's enforcement proceedings at law." *Virginia Office for Protection & Advocacy v. Stewart*, 131 S. Ct. 1632, 1642 (2011) (Kennedy, J., concurring). In this case, the plaintiffs have no "defense" that they could assert in an enforcement action by the State of California. Consequently, these cases do not pertain either.

As the *Shaw* Court explained, the right to invoke the supremacy of federal law in cases of threatened enforcement of pre-empted State law is essentially an application of the equitable principles underlying *Ex parte Young*. *See Shaw*, 463 U.S. at 96 n.14 (citing *Ex parte Young*, 209 U.S. at 160-62).[9] Suits of this type trace their history as far back as *Osborn v. Bank of the United States*, 22 U.S. (9 Wheat.) 738 (1824), and are now largely uncontroversial. Like the uses of the Supremacy Clause described above, such suits seek to assert federal constitutional or statutory rights — often, an implied federal right not to be subject to pre-empted State coercive authority — that void State enforcement proceedings. *See Ex parte Young*, 209 U.S. at 155-56. Thus, although the

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[9] The question presented in *Ex parte Young* was not whether the plaintiff had a cause of action, but whether sovereign immunity would bar such a suit. The underlying equitable principles were not contested.

regulated party brings the lawsuit, the Supremacy Clause is still a shield dependent on a federal right or defense, not a cause of action for affirmative relief.

Historically, in fact, the type of equitable action asserted in *Shaw* could *only* be used as a shield, and the Supremacy Clause functioned only as the rule of decision. The plaintiff in *Ex parte Young* sought an anti-suit injunction under federal equity law, which supplied an equitable cause of action. *See generally* John Harrison, Ex Parte Young, 60 Stan. L. Rev. 989 (2008); *id.* at 1014. In cases like *Ex parte Young*, plaintiffs seeking such an injunction had to show (1) a legal defense (such as pre-emption) to an impending legal action and (2) an argument that waiting to assert the defense at law would not be an adequate remedy. *Id.* at 997-999, 1014; *Scott v. Donald*, 165 U.S. 107, 114 (1897) ("[T]he circuit courts of the United States will restrain a state officer from executing an unconstitutional statute of the state when to execute it would be to violate rights and privileges of the complainant that had been guarantied by the constitution, and would do irreparable damage and injury to him[.]") (quoting *Ex parte Tyler*, 149 U.S. 164, 191 (1893)); *see also* IV John Norton Pomeroy, *A Treatise on Equity Jurisprudence as Administered in the United States of America* § 1363, p. 981-83 (5th ed. 1941); *Williams v. Neely*, 134 F. 1, 4 (1904) (discussing an equity case brought to pre-emptively assert a contractual defense). Those two prerequisites have been satisfied in every case in which this Court has upheld relief based on federal supremacy, whether they have been explicitly addressed or not. *Virginia Office for Protection & Advocacy*, 131 S. Ct. at 1642 (majority opinion) (plaintiff must have "a federal

right" in order to seek judicial relief under *Ex parte Young*). By contrast, Respondents in this case, lacking a federal right or defense, could not have made out such as claim.

In addition, under equity, only negative injunctive relief was permitted. The *Ex parte Young* Court emphasized that the rule it announced would not extend to offensive uses of equitable causes of action, like Respondents' effort to force States to take affirmative action to conform to federal law in the absence of a federal right. *Ex parte Young*, 209 U.S. at 158; *see also* Henry M. Hart, Jr., *The Relations Between State and Federal Law*, 54 Colum. L. Rev. 489, 516 (1954) (distinguishing between negative injunctive relief permitted by *Ex parte Young* and affirmative relief foreclosed by the Eleventh Amendment). This Court has recently reiterated that very point. *Virginia Office for Protection & Advocacy*, 131 S. Ct. at 1639 (no right under *Ex parte Young* to seek specific performance of State's contract).

Shaw and its antecedents, therefore, support use of the Supremacy Clause by litigants with federal defenses to prospective State enforcement action, but not otherwise. The cases erroneously cited by the Ninth Circuit panel to support its more expansive reading of the Clause, to create a federal cause of action without a federal statutory right or defense, are not to the contrary. *Accord Verizon Md. Inc. v. Public Serv. Comm'n*, 535 U.S. 635, 640 (2002) (enforcement of State administrative ruling), *Gade v. National Solid Wastes Mgmt. Ass'n*, 505 U.S. 88, 94 (1992) (enforcement of State licensing laws), *Ray v. Atlantic Richfield Co.*, 435 U.S. 151, 156 (1978)

(enforcement of State oil tanker restrictions); *Florida Lime & Avocado Growers, Inc. v. Paul*, 373 U.S. 132, 134 (1963) (enforcement of State agricultural standards).

B. Respondents' Cause Of Action Is Inconsistent With Existing Federal Statutory Remedies.

To expand the cause of action contemplated by *Ex parte Young* and *Shaw* to plaintiffs without federal rights or defenses, furthermore, would bring it into tension with the causes of action actually enacted by Congress, and with the limitations this Court has placed on implying additional statutory causes of action.

All parties, including Respondents, appear to agree that Congress did not intend 42 U.S.C. § 1396a(a)(30)(A) of the Medicaid Act to create a private right of action, and that this Court's test for implying a statutory cause of action therefore is not met. *Stoneridge Inv. Partners, LLC v. Scientific-Atlanta*, 552 U.S. 148, 164-65 (2008). And yet Respondents have brought suit to enforce that provision against the State of California for their own benefit. To put the matter most starkly, all parties agree that Section 1396a does not create a private cause of action, *but Respondents are suing under it anyway*, aided by nominal reliance on the Supremacy Clause. Respondents' use of the Supremacy Clause would override the limitations this Court has properly placed on implied statutory causes of action.

The consequences would be extraordinary. Today, this Court finds implied statutory causes of

action "*only* if the underlying statute can be interpreted to disclose [congressional] intent to create one[.]" *Stoneridge*, 552 U.S. at 164-65 (emphasis added). That rule rests on the sound presumption that "[t]he decision to extend the cause of action is for Congress, not for us." *Id.* at 165. This Court's role has been "to interpret the statute Congress has passed to determine whether it displays an intent to create not just a private right but also a private remedy." *Alexander v. Sandoval*, 532 U.S. 275, 286 (2001). And in the absence of Congressional intent, this Court has held "that a cause of action does not exist and courts may not create one, no matter how desirable that might be as a policy matter, or how compatible with the statute." *Sandoval*, 532 U.S. at 286-87. Respondents' theory, in contrast, would mean that *every* federal statute implicitly authorizes a private cause of action against State or local governmental defendants under the Supremacy Clause, whether it creates causes of action or affirmative defenses or not, so long as it has potentially pre-emptive effects. By limiting implied causes of action before, this Court has rejected that position, and should do so again.

Respondents' Supremacy Clause theory would also supplant much of Section 1983, which (as mentioned above) creates an injunctive remedy for violations of federal rights but not a free-standing cause of action in all instances of alleged pre-emption. *See, e.g., Gonzaga Univ. v. Doe*, 536 U.S. 273, 283 (2002) (plaintiffs may not sue under § 1983 for State violation of federal statute unless the statute creates an "unambiguously conferred right"). Virtually every suit for an injunction under Section 1983, after all, could be characterized as alleging

federal pre-emption, and under the Ninth Circuit's reasoning all a plaintiff would then need to establish is standing. Respondent's Supremacy Clause cause of action, in other words, renders a statutory cause of action and remedy almost entirely redundant.

That effect is even more striking because members of the Congress that enacted Section 1983's predecessor in 1871 evidently believed that its equitable remedies were *new*, and necessary to vindicate federal rights. Senator Frelinghuysen supported the bill on the ground that an "injured party should have an original action in our Federal courts, so that by injunction . . . he could have relief" for violations of his rights. Cong. Globe, 42d Cong., 1st Sess., at 501 (1871). Senator Carpenter said that before the Fourteenth Amendment, Congress lacked the "affirmative power" to "save the citizen from the violation of any of his rights by the State Legislatures[.]" "[T]he only remedy," he said, "was a judicial one *when the case arose*." *Id.* at 577 (emphasis added). Just as the Supremacy Clause's history indicates, vindication of federal rights had to await occasion for defensive use. As for affirmatively compelling State compliance with federal law, Representative Lowe understood it to be impossible without Section 1983: "The Federal Government cannot serve a writ of *mandamus* upon State Executives . . . to compel them to . . . protect the rights, privileges, and immunities of citizens. There is no legal machinery for that purpose. . . . Hence this bill throws open the doors of the United States courts to those whose rights under the Constitution are denied or impaired." *Id.* at 376. Even against the background of federal cases such as *Osborn*, which acknowledged an *Ex parte Young*-type action

as early as 1824, Congress understood itself to be creating a new equitable remedy that would not have existed otherwise. Respondents' argument that the same remedy was always available under the Supremacy Clause disregards this evidence of congressional intent.

The cause of action asserted by Respondents would be a departure from the Supremacy Clause's history and meaning and would radically rework the principles and authorities governing the assertion of federal supremacy against the States today. Because Respondents lack either a federal cause of action or a federal equitable right to be free of pre-empted State enforcement, federal law gives them no basis for relief.

CONCLUSION

The Court should reverse the judgment of the United State Court of Appeals for the Ninth Circuit.

Respectfully submitted,

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May 25, 2011

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U.S. Department of Justice
Office of the Solicitor General

Supreme Court, U.S.
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November 18, 2011

Honorable William K. Suter
Clerk
Supreme Court of the United States
Washington, D.C. 20543

Toby Douglas, Director, California Department of Health Care Services v. Independent Living Center of Southern California, Inc., et al., S. Ct. No. 09-958

Toby Douglas, Director, California Department of Health Care Services v. California Pharmacists Association, et al., S. Ct. No. 09-1158

Toby Douglas, Director, California Department of Health Care Services v. Santa Rosa Memorial Hospital, et al., S. Ct. No. 10-283 (Argued Oct. 3, 2011)

Dear Mr. Suter:

On November 4, 2011, the Court directed the parties and the Solicitor General to address the following question: "What should be the effect, if any, of the developments discussed in the letter submitted by the Solicitor General on October 28, 2011, on the proper disposition of this case?" For the reasons set forth below, it is the view of the United States that while those developments alter the context in which the cause-of-action issue arises in these consolidated cases in a significant way, it remains appropriate for the Court to resolve that issue.

1. As discussed in the October 28, 2011, letter, the Centers for Medicare & Medicaid Services (CMS) recently approved several modified State Plan Amendments (SPAs) submitted by California that cover Medicaid provider rate reductions enacted by the California Legislature in Assembly Bill 5 (AB 5) and Assembly Bill 1183 (AB 1183), including certain rate reductions that are currently subject to preliminary injunctions entered in the consolidated cases under review in *Douglas*. California also withdrew its formal request for reconsideration of the remaining disapproved SPAs at issue in the *Douglas* cases. As a result, for the time period prior to January 1, 2011, California is no longer seeking CMS approval for any of the rate reductions for the period during which they had been preliminarily enjoined by a court order entered in the consolidated *Douglas* cases. And, for the period of time beginning on or after January 1, 2011, CMS has now approved many of the enjoined rate reductions for retroactive implementation (including recoupment of amounts overpaid). See 10/28/11 Letter & Chart (detailing recent developments).

2. "[A] federal court has no authority 'to give opinions upon moot questions or abstract propositions, or to declare principles or rules of law which cannot affect the matter in issue in the case before it.'" *Church of Scientology* v. *United States*, 506 U.S. 9, 12 (1992) (quoting *Mills* v.

Green, 159 U.S. 651, 653 (1895)). The parties must at all times have "a 'personal stake in the outcome' of the lawsuit." *Lewis* v. *Continental Bank Corp.*, 494 U.S. 472, 478 (1990) (quoting *City of L.A.* v. *Lyons*, 461 U.S. 95, 101 (1983)). And if an intervening event occurs that "makes it impossible for the court to grant 'any effectual relief whatever' to a prevailing party," the case must be dismissed. *Church of Scientology*, 506 U.S. at 12 (quoting *Mills*, 159 U.S. at 653). The recent developments detailed in the Solicitor General's October 28, 2011, letter do not moot the consolidated cases in *Douglas*. Most, if not all, of those cases continue to present a live controversy.

The consolidated certiorari petitions encompass five lawsuits that produced several district court and court of appeals opinions—all of which ultimately resulted in a court order preliminarily enjoining the challenged rate reductions as inconsistent with 42 U.S.C. 1396a(a)(30)(A).

a. In two of the three cases encompassed in No. 09-1158 (*Cal. Pharm.*), the lower courts preliminarily enjoined the one-percent rate reduction for hospital outpatient services; the five-percent reduction for prescription drugs, distinct part skilled nursing facilities, distinct part adult and pediatric subacute facilities, and adult day health centers; and the rate cap on non-contracting hospitals—all imposed by AB 1183. See U.S. Merits Stage Amicus Br. 6-7; 10/28/11 Chart. In No. 10-283 (*Santa Rosa*), the lower court preliminarily enjoined the ten-percent rate reduction and cap on non-contracting hospitals imposed by AB 5. See U.S. Merits Stage Amicus Br. 8; 10/28/11 Chart.

All of the rate reductions so enjoined were encompassed in the SPAs recently approved by CMS. For the time period before 2011, the SPAs only covered (and CMS only approved) those rate reductions for the time period during which no preliminary injunction was in effect. But the SPAs also covered (and CMS also approved) many of those rate reductions for time periods beginning on or after January 1, 2011, regardless of whether an injunction was then in effect.[1] Thus, CMS has authorized California to retroactively implement those 2011 reductions for a certain number of months and to recoup amounts overpaid during that time period. See generally 10/28/11 Letter & Chart.

Based on CMS's recent approvals, California is authorized to retroactively implement those rate reductions. But the preliminary injunctions preclude California from doing so. Nothing in the language of the injunctions rests on the absence of CMS approval and, unless set aside, California must continue to comply despite CMS's subsequent approval of the rate reductions. See, *e.g.*, *California Pharmacists Ass'n* v. *Maxwell-Jolly*, No. 09-55365 (9th Cir. Mar. 3, 2010) (remanding to the district court to enjoin AB 1183's rate reductions for certain hospital services); *California Pharmacists Ass'n* v. *Maxwell-Jolly*, No. 09-722 (C.D. Cal. June 16, 2010) (on remand, ordering "Director, his agents, servants, employees, attorneys, successors, and all those working in concert with him to refrain from enforcing Cal. Welf. & Inst. Code 14105.191 and 14166.245 with respect to services provided under the fee-for-service Medi-Cal program, by refraining from reducing by five

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[1] The 2008 SPAs did not cover (and CMS did not approve) 2011 reductions for distinct part adult and pediatric subacute facilities. See 10/28/11 Chart.

percent payments to hospitals for distinct part nursing facility services and subacute services, by refraining from reducing by one percent payments to hospitals for outpatient services"); *California Pharmacists Ass'n* v. *Jolly*, 630 F. Supp. 2d 1144, 1154 (C.D. Cal. 2009) (ordering the "Director, his agents, servants, employees, attorneys, successors, and all those working in concert with him to refrain from enforcing Cal. Welf. & Inst. Code § 14105.191, as modified by AB 1183 beginning on March 9, 2009, by refraining from reducing by five percent payments to [adult day health centers] provided under the Medi-Cal fee-for-service program"); *Managed Pharmacy Care* v. *Maxwell Jolly*, No. 09-382 (C.D. Cal. Feb. 27, 2009), slip. op. 17-18 (ordering "Director, his agents, servants, employees, attorneys, successors, and all those working in concert with him to refrain from enforcing Cal. Welf. & Inst. Code § 14105.191(b)(3), as modified by AB 1183 beginning on March 1, 2009, by refraining from reducing five percent payments to pharmacies for prescription drugs (including prescription drugs and traditional over-the-counter drugs provided by prescription) provided under the Medi-Cal fee-for-service program"). Cf. 10/3/11 Oral Argument Tr. 42 (Oral Argument Tr.) (noting that the district court "granted a broader preliminary injunction" and did not consider an "alternative argument" that would have provided that the injunction "should stay into effect at least until [the Department of Health and Human Services (HHS)] acts"). If the judgments of the court of appeals were reversed, and the injunctions vacated, California would then be free to retroactively implement the rate reductions in part and recoup amounts overpaid. In the meantime, California remains enjoined from implementing its (now approved) rate reductions. Because the subsisting preliminary injunctions in *Douglas* "continue[] to have an impact on the parties" that can be redressed by this Court, "the case remains alive." *Firefighters Local Union No. 1784* v. *Stotts*, 467 U.S. 561, 569 (1984); *ibid.* (rejecting mootness argument and reasoning that "[i]t would appear from its terms that the injunction is still in force and that unless set aside must be complied with").

b. In No. 09-958 (*Indep. Living*), the lower courts preliminarily enjoined the ten-percent rate reduction imposed by AB 5 for physicians, clinics, dentists, optometrists, adult day health centers, prescription drugs, non-emergency medical transportation, and home health services. U.S. Merits Stage Amicus Br. 4-5; 10/28/11 Chart. California subsequently withdrew its request for approval of the rate reductions associated with some of those services (physicians, clinics, dentists, optometrists, adult day health centers, and prescription drugs). 10/28/11 Chart. Accordingly, the preliminary injunctions have no continuing impact on California with respect to those rate reductions. See *Honig* v. *Students of Cal. Sch. for the Blind*, 471 U.S. 148, 149 (1985) (per curiam) ("'[T]he question whether a preliminary injunction should have been issued here is moot, because the terms of the injunction . . . have been fully and irrevocably carried out.' * * * No order of this Court could affect the parties' rights with respect to the injunction we are called upon to review.") (quoting *University of Tex.* v. *Camenisch*, 451 U.S. 390, 398 (1981)). CMS did, however, approve the ten-percent rate reductions for non-emergency medical transportation and home health services, though only for the period of time *before* the district court issued its preliminary injunction. See 10/28/11 Chart. While that too would suggest that the preliminary injunction has no continuing impact on California, a request for a permanent injunction that appears to encompass retrospective relief remains pending and has been stayed pending this Court's decision. See Mot. for Summ. J. at 3-4, *Independent Living Ctr. of S. Cal., Inc.* v. *Maxwell-Jolly*, No. 08-03315 (C.D. Cal. June 7, 2010); Minute Order, *Independent Living Ctr. of S. Cal., Inc.*, *supra* (June 17, 2010) (No. 08-03315).

Accordingly, portions of No. 09-958 appear to remain live as well.

c. The recent developments set forth in the October 28, 2011, letter had no impact on the other case encompassed in No. 09-1158: *Dominguez* v. *Schwarzenegger*, No. 09-2306 (N.D. Cal.). As the government explained in its amicus brief (U.S. Merits Stage Amicus Br. 4), Senate Bill 6 (SB 6), which was preliminarily enjoined in *Dominguez*, reduced a cap on the State's maximum contribution to wages and benefits paid to employees by counties for In-Home Supportive Services. None of the SPAs submitted by California encompassed that reduced cap and, accordingly, the recent SPA approvals have no impact on that case. See 10/28/11 Letter at 1 n.*.

That said, after the district court issued its preliminary injunction, the California Legislature amended SB 6 to delay implementation until July 2012 and until a court first validates the reduced cap. See U.S. Merits Stage Amicus Br. 4; Cal. Welf. & Inst. Code § 12306.1(d)(6)-(7) (West Supp. 2011). Thus, while CMS's recent approvals do not affect the *Dominguez* case, the statutory amendment to SB 6, which requires court approval before the reduced cap could become effective, could raise questions regarding whether a continuing controversy exists that would provide a basis for ongoing enforcement of the preliminary injunction in that case.

3. The question presented in these consolidated cases is whether Medicaid providers and beneficiaries may maintain a private right of action under the Supremacy Clause to assert that 42 U.S.C. 1396a(a)(30)(A) preempts state law reducing reimbursement rates. The recent developments set forth in the October 28, 2011, letter do alter the circumstances in which that issue arises, but it remains appropriate for the Court to resolve that issue.

It was suggested at oral argument that Medicaid providers and beneficiaries might have a limited right of action to sue state officials to enjoin the operation of state law that imposes rate reductions allegedly in violation of Section 1396a(a)(30)(A) *before* CMS approves the relevant rate reductions, even if they do not have a right of action to sue state officials to enjoin the operation of state law *after* CMS has concluded that the rate reductions comply with Section 1396a(a)(30)(A). See, *e.g.*, Oral Argument Tr. 12-13, 41, 59. On that theory, the consolidated cases would now stand in a very different posture as a result of the recent SPA approvals by CMS because respondents would no longer have any right of action (apart from whatever action they may have under the Administrative Procedure Act (APA)) to challenge the approved rates. Of course, petitioner's arguments (and those of the United States) would not recognize a cause of action to challenge state rate reductions before or after CMS approval.

And respondents' position is not entirely clear. On the one hand, the legal theory respondents advanced in this Court would not appear to provide a doctrinal basis for making this distinction, and respondents maintained at oral argument that they would have a cause of action under the Supremacy Clause even "if the agency approves the rates." See Oral Argument Tr. 54; *id.* at 53 ("[T]o be sure, I have a cause of action."); *id.* at 55 ("I still think you can bring an action under the Supremacy Clause."). As respondents explained, "it's the State acting pursuant to what the agency has approved, that if you still thought it violated Federal law, [that] would be a basis for seeking a

Supremacy Clause action." *Id.* at 57.[2] On the other hand, respondents also indicated that they would be "perfectly comfortable" with a ruling limiting potential injunctive relief to circumstances in which CMS had not yet approved rates, that they had advanced such an "alternative argument" in the district court, and that the "obvious solution" would be to challenge approved rates under the APA rather than in an action under the Supremacy Clause. Oral Argument Tr. 41, 42, 57.

Although the changed circumstances could be a basis for considering whether the writ of certiorari should be dismissed as improvidently granted, given that the posture of the case is now significantly different than it was when certiorari was granted, one difficulty with that approach is that CMS's approval of the rate reductions at issue in this case permits retroactive implementation of the enjoined reductions for some period of time on or after January 1, 2011, and the preliminary injunctions do not expire on their own terms upon CMS approval of the challenged rates. Unless the preliminary injunctions are vacated, the State is precluded from retroactively implementing approved rate reductions and recouping amounts overpaid during the interim period.[3] Thus, if the Court considers dismissing the writ, then the courts below would still need to vacate the injunctions. Alternatively, to the extent the Court believes that the absence of CMS approval may be an important consideration in determining the availability of any right of action for injunctive relief, it could consider vacating the decisions below and remanding with instructions to vacate the preliminary injunctions.

4. To be sure, CMS's approval affects the merits of respondents' preemption claims. Respondents argued below, and the court of appeals held, that the challenged rate reductions conflict with Section 1396a(a)(30)(A). CMS, which administers the federal Medicaid program on behalf of the Secretary of HHS, has now determined that many of those same rate reductions (as modified)

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[2] Respondents' subsequent actions confirm that approach. On October 27, 2011, CMS approved several 2011 SPAs encompassing ten-percent rate reductions provided for under laws passed by the California Legislature in 2011 that were not before the lower courts in the *Douglas* cases. See 10/28/11 Letter at 3. Immediately thereafter, several of the respondents filed suits for injunctive relief against both state and federal officials. The complaints assert, among other things, a cause of action under the Supremacy Clause to enforce Section 1396a(a)(30)(A), as well as an APA claim against the Secretary. See Compl. ¶¶ 83-84, 91-93, *California Hosp. Ass'n* v. *Douglas*, No. 11-9078 (C.D. Cal. Nov. 1, 2011); Compl. ¶¶ 32, 35, *Managed Pharmacy Care* v. *Sebelius*, No. 11-9211 (C.D. Cal. Nov. 4, 2011).

[3] Moreover, the question whether providers and beneficiaries have any right of action to sue state officials to enjoin the operation of state law during the administrative review process is a recurring issue—and one that may evade fulsome appellate review if CMS's ultimate approval of a SPA somehow eliminated a private right of action. See *Burlington N. R.R. Co.* v. *Brotherhood of Maint. of Way Employees*, 481 U.S. 429, 436 n.4 (1987) ("Because these same parties are reasonably likely to find themselves again in dispute over the issues raised in this petition, and because such disputes typically are resolved quickly by executive or legislative action, this controversy is one that is capable of repetition yet evading review.").

comply with Section 1396a(a)(30)(A). See Approval Letter for SPA Nos. 08-009A, 08-009B1, 08-009D & Approval Letter for SPA No. 10-24 (attachments to 10/28/11 Letter). CMS's legal determination is entitled to deference, see *Chevron U.S.A. Inc.* v. *NRDC*, 467 U.S. 837 (1984); *National Cable & Telecomms. Ass'n* v. *Brand X Internet Servs.*, 545 U.S. 967 (2005), and CMS's assessment that approval is warranted on the basis of the State's new submissions would be subject to judicial review under the APA (if at all), only under the arbitrary and capricious standard. See 5 U.S.C. 706(2)(A). Indeed, respondents appeared to agree that, once CMS approved the rate reductions, they would have "zero hope of prevailing." See Oral Argument Tr. 55.

But that does not render the cases moot.[4] Nor does it suggest that the Court should vacate the judgment below and remand for reconsideration of the merits of respondents' preemption claims. First, CMS determined that the rate reductions complied with Section 1396a(a)(30)(A) based on a substantive standard that is materially different than the one applied by the Ninth Circuit and advocated by respondents. The Ninth Circuit has consistently construed Section 1396a(a)(30)(A) to require a State to set reimbursement rates that "bear a reasonable relationship" to provider costs and to consider "responsible cost studies" *before* establishing such rates, as well as to bar rate reductions solely for budgetary reasons. See, *e.g.*, *Orthopaedic Hosp.* v. *Belshe*, 103 F.3d 1491, 1496, 1499 n.3 (1997), cert. denied, 522 U.S. 1044 (1998); *Independent Living Ctr. of S. Cal., Inc.* v. *Maxwell-Jolly*, 572 F.3d 644, 652-657 (2009), cert. granted in part, No. 09-958 (argued Oct. 3, 2011); *California Pharmacists Ass'n* v. *Maxwell-Jolly*, 596 F.3d 1098, 1106, 1115 (2010), cert. granted in part, No. 09-1158 (argued Oct. 3, 2011). The government's amicus brief at the petition stage in *Orthopaedic Hospital* made clear that the Secretary of HHS disagreed with the Ninth Circuit's cost-based construction of Section 1396a(a)(30)(A). See U.S. Br. at 7-9, *Belshe* v. *Orthopaedic Hosp.*, 522 U.S. 1044 (1998) (No. 96-1742). Yet, the Ninth Circuit declined to defer to the federal agency responsible for administering the Medicaid Act. See *Independent Living Ctr. of S. Cal., Inc.*, 572 F.3d at 654 ("Whatever the merits of the Solicitor General's views, we owe them no deference in this case."). But cf. *Alaska Dep't of Health & Social Servs.* v. *CMS*, 424 F.3d 931, 938-942 (9th Cir. 2005) (deferring to CMS's disapproval of SPA based on noncompliance with Section 1396a(a)(30)(A)). And some of the respondents continue to argue that the Ninth Circuit's standard controls. See Compl. ¶ 62(a), *California Hosp. Ass'n*, No. 11-9078 (C.D. Cal. Nov. 1, 2011) (alleging that "[b]ecause California is within the jurisdiction of the Ninth Circuit Court of

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[4] *Lewis*, *supra*, is not to the contrary. In *Lewis*, the Court held that a Commerce Clause claim was rendered moot when Congress amended the Bank Holding Company Act of 1956, 12 U.S.C. 1841 *et seq.*, to permit States to prohibit an out-of-state bank holding company from owning the type of in-state "bank" at issue in that case. 494 U.S. at 474. The intervening event was a congressional enactment that, all parties conceded, validated the State's challenged action. Here, the intervening event is an agency approval that, while entitled to deference (see p. 6, *supra*), does not indisputably resolve the underlying preemption claims. Moreover, the Court in *Lewis* granted certiorari to decide the Commerce Clause issue; here, the Court granted certiorari to decide whether a cause of action exists—and *that* question remains even after CMS's approval of certain rate reductions at issue. Accordingly, unlike in *Lewis*, the parties still have a "personal stake," 494 U.S. at 478 (quoting *Lyons*, 461 U.S. at 101), in the outcome of these cases.

Appeals, the Secretary is bound to apply the Ninth Circuit's interpretation of the Medicaid Act, including Section 30(A), when evaluating California SPAs for compliance with the Medicaid Act"); Mot. for Prelim. Inj. at 5-7, *Managed Pharmacy Care*, No. 11-9211 (C.D. Cal. Nov. 4, 2011) (explaining difference between Secretary's interpretation of Section 1396a(a)(30)(A) and that of the Ninth Circuit).

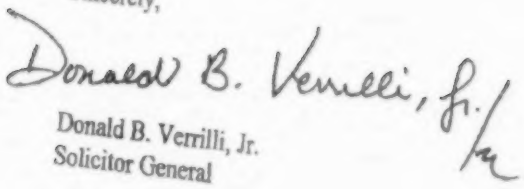
Second, this Court granted review limited to the threshold question whether the Supremacy Clause provides a cause of action to Medicaid providers and beneficiaries who assert that state law conflicts with the requirements of Section 1396a(a)(30)(A)—*not* whether the court of appeals erred in concluding that such a conflict actually existed. The Court expressly declined to grant review on the State's substantive obligations under Section 1396a(a)(30)(A). Even if intervening events alter the underlying merits of respondents' claims, this Court can answer the question on which it granted certiorari. Cf. *Wilkie* v. *Robbins*, 551 U.S. 537, 567 (2007) ("Because neither *Bivens* nor RICO gives Robbins a cause of action, there is no reason to enquire further into the merits of his claim."); *California* v. *Sierra Club*, 451 U.S. 287, 298 (1981) ("Our ruling that there is no private cause of action permitting respondents to commence this action disposes of the cases: we cannot consider the merits of a claim which Congress has not authorized respondents to raise.").

Third, the government explained in its amicus brief at the petition stage that the Secretary had then recently disapproved the SPAs at issue and that the State had initiated a formal hearing process. U.S. Pet. Stage Amicus Br. 20. The government recommended against review because, among other reasons, the cases involved preliminary injunctions and were in an interlocutory posture that would allow the courts below to consider developments in the ongoing administrative hearing process. *Id.* at 21. The Court nonetheless granted certiorari to answer the cause-of-action question. Given that the Court has granted certiorari, and the parties have now briefed the case and presented oral argument, the circumstances bearing on whether the Court should resolve the cause-of-action issue are different than when the government previously recommended against review. Cf. *Pacific Bell Tel. Co.* v. *Linkline Commc'ns, Inc.*, 555 U.S. 438, 447 (2009) (noting "prudential concerns" such as the fact that "the parties have invested a substantial amount of time, effort, and resources in briefing and arguing the merits of this case").

5. One final point is worth noting. CMS's retroactive approval of the SPAs confirms what the regulations make clear: a State can implement amendments to its State plan prior to CMS approval. A SPA that is approved can "become effective" as early as the first day of the calendar quarter in which the amendment is submitted. 42 C.F.R. 447.256(c); see 42 C.F.R. 430.20(b)(2). That is precisely what happened here. For example, California submitted several SPAs on September 30, 2008; upon approval, the earliest reductions became effective July 1, 2008. See Approval Letter for SPA Nos. 08-009A, 08-009B1, 08-009D (attachment to 10/28/11 Letter). To be sure, a State that chooses to implement amendments prior to approval does so at the risk that CMS will later disapprove those amendments. But the Medicaid regulations clearly contemplate and authorize retroactive approval of SPAs.

I would appreciate it if you would circulate this letter to the Members of the Court.

Sincerely,



Donald B. Verrilli, Jr.
Solicitor General

cc: Counsel of Record

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By Hand Delivery
Honorable William K. Suter
Clerk
Supreme Court of the United States
1 First Street, N.E.
Washington, DC 20543

Re: *Douglas v. Independent Living, California Pharmacists, Santa Rosa*
Supreme Court of the United States, Case Nos. 09-958, 09-1158, 10-283

Dear Mr. Suter:

Pursuant to the Court's order of November 4, 2011, we write to address the "effect, if any, of the developments discussed in the letter submitted by the Solicitor General on October 28, 2011, on the proper disposition of this case." In that letter (the Oct. 28 SG letter), the Solicitor General advised the Court that, on October 27, 2011, the Centers for Medicare & Medicaid Services (CMS) approved many of the pending State Plan Amendments governing the provider payments at issue in the underlying petitions for certiorari.

CMS's action affects the pending cases in two ways. First, CMS's action bolsters the State's position in these cases, including with respect to some issues about which the Court posed questions during oral argument on October 3, 2011. Second, although the disputes among the parties as to some components of the underlying payment reductions are now resolved, all three consolidated petitions continue to present live controversies appropriate for resolution by this Court.

I. BACKGROUND

Under review in the three consolidated petitions are seven separate Ninth Circuit decisions that either affirmed injunctions of, or ordered enjoined, California statutory enactments that would have reduced the State's Medicaid expenditures. Six of the seven decisions involved state statutes that reduced payments to Medicaid providers (generally by specific percentages). As to these reductions, the State submitted State Plan Amendments (SPAs) to CMS within the quarter in which the reductions were to take effect, as provided by CMS regulations. *See* 42 C.F.R. § 430.20. The seventh decision, *Dominguez*, at issue in *California Pharmacists*, No. 09-1158, involves statutory action as to which no SPA was submitted or required. Specifically, the enactment challenged in *Dominguez*, SB 6, capped the State's contribution to wages and benefits paid to providers of In-Home Supportive Services (IHSS), but did not change the methodology

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for determining rates as set forth in the applicable State Plan (i.e., collective bargaining between counties and provider unions).

On October 27, 2011, CMS announced that it had approved many of the SPAs governing the payment reductions challenged in the underlying cases (excluding *Dominguez* for which no SPA was required or submitted). The scope and effect of CMS's approvals are set forth in the table attached as Exhibit A hereto. In general, California's payment reductions were approved as follows:

- ***Pre-injunction payment reductions approved (column IV of Exhibit A).*** CMS approved all the payment reductions to the extent the State was able to implement them *before* being enjoined from doing so. Thus, for example, CMS approved California's *pre-injunction* implementation of certain 10 percent reductions under AB5, and one and five percent reductions under AB1183. *See* Ex. A, col. IV. Because California was able to implement these reductions for the approved periods, it has no basis to seek any additional payments from providers for services rendered during those periods. However, as described in more detail in Part III, *infra*, providers in *Independent Living* have filed two motions – both of which are stayed pending this Court's proceedings – that seek retroactive relief for the pre-injunction period.[1]

- ***California's request for injunction-period payment reductions partially withdrawn (column V of Exhibit A).*** Based on negotiation and consultation with CMS, California agreed to withdraw its requests for SPA approval of certain payment reductions for at least some of the periods in which those reductions were enjoined. It did so even though it believed the reduced payments complied with federal law *when approval initially was sought*, out of a concern that, to seek full retroactive relief now for the entire period of the injunctions (which were in effect 2-3 years and longer) could impose hardship on providers and ultimately affect Medicaid beneficiaries' access to care. *See* Letter from Derek E. Backus, Senior Counsel, DHCS, to Benjamin R. Cohen, Presiding Officer, CMS (Oct. 27, 2011) (attached to the Oct. 28, 2011 SG letter). The periods during which California's payment reductions were enjoined, for which California agreed to withdraw its requests for approval, are set forth in column V of Exhibit A. For these periods of time, California has no basis to seek recoupment from providers for payments made under the injunctions, and providers have no basis to demand any further reimbursement.

- ***Injunction-period payment reductions approved to the extent not withdrawn by California (column VI of Exhibit A).*** California did not withdraw its requests for SPA approval for certain periods during which its rate reductions were enjoined. With respect to these periods, its requests were approved, as reflected in column VI of Exhibit A. Thus, if the Court rules in

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[1] The Ninth Circuit held that the State waived its Eleventh Amendment immunity when it removed the case at issue in *Independent Living*, No. 09-958. *Indep. Living* Pet. App. 29-37. The cases at issue in the *California Pharmacists*, 09-1158, and *Santa Rosa*, 10-283, were initially filed in federal court and therefore do not present any waiver issue.

California's favor in the present cases, and the underlying injunctions are vacated as a result, California will have a right to seek reimbursement from providers for excess payments that it was compelled to make to them in order to comply with the lower court's injunctions.

II. SPA APPROVAL BOLSTERS CALIFORNIA'S POSITION IN THESE CASES

CMS's approval of California's SPAs bolsters two aspects of the State's position that were the subject of questions from the Court at oral argument on October 3, 2011.

A State may implement a rate reduction while awaiting SPA approval. At oral argument, several questions from the Court suggested that the Medicaid Act bars a State from implementing a rate reduction until it obtains CMS approval of a SPA, and that a State should be enjoined from implementing a rate reduction while awaiting SPA approval. *See* Tr. of Proceedings at 6:16-23 (Kagan, J.); *see also id.* at 41:9-16 (Sotomayor, J.); *id.* at 50:16-24 (Kagan, J.). As we explained at oral argument, and also in prior briefing in the Court, no statute or regulation requires a State to obtain SPA approval before implementing a rate reduction. *See* Tr. of Proceedings at 6-7; Pet'rs' Supplemental Br., *Cal. Pharm.*, No. 09-1158 (filed Dec. 20, 2010).[2] To the contrary, the only regulation governing the issue merely requires that the State submit its SPA within the quarter in which the SPA is to take effect. 42 C.F.R.§ 430.20.

CMS's decision to approve payment reductions *retroactively* to the quarter in which the SPAs were submitted (in some cases, more than three years ago) confirms that California's understanding of the SPA approval requirements is correct and is consistent with the views of the federal government. If the Medicaid Act barred a state from implementing a rate reduction until CMS approval is obtained, CMS could not – and would not – have approved any payment reductions retroactively.

Permitting parallel private enforcement litigation undermines congressional intent regarding centralized administrative enforcement of Medicaid and prejudices the State's position in CMS administrative proceedings. We have previously advised the Court how injunctions in private lawsuits interfere with the administrative enforcement scheme intended by Congress and, specifically, may materially prejudice the State in terms of its ability to obtain SPA approval. *See, e.g.*, Brief for Petitioners 28-29, *Douglas v. Indep. Living Ctrs., Cal. Pharm., Santa Rosa*, Nos. 09-958, 09-1158, 10-283 (filed May 19, 2011); *see also* Pet'r's Supplemental Br. 5-6, *Douglas v. Indep. Living Ctr.*, No. 09-958 (filed Dec. 14, 2010). Further, such lawsuits draw out the process: in the vast majority of cases, SPAs are approved or otherwise consensually resolved within 90 days from when they are submitted, and the present cases are the exception that proves the rule. *See* Tr. of Proceedings at 11:11-16; *id.* at 12-13.

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[2] And certainly no statute or regulation confers a "right" on private parties to judicially enforce such a requirement, even if such a requirement could be found to exist.

The SG's letter and its attachments confirm the prejudicial effect of court injunctions. California felt compelled to partially withdraw its requests for SPA approval out of a concern, shared by CMS, that seeking full retroactive approval and implementation of the payment reductions could ultimately affect beneficiaries' access to services. *See* Letter from Derek E. Backus, Senior Counsel, DHCS, to Benjamin R. Cohen, Presiding Officer, CMS (Oct. 27, 2011) (attached to the Oct. 28, 2011 SG letter) ("DHCS has a genuine concern, which CMS shares, that recoupment for such a lengthy period of time could create a real access problem for Medi-Cal beneficiaries who rely on those providers subject to a multi-year recoupment."). DHCS took this action notwithstanding that it "continues to believe that, at the time the SPAs were submitted, the rates satisfied [§ 30(A)], a conclusion with which we understand CMS does not disagree." *Id.*

III. A LIVE CONTROVERSY REMAINS BEFORE THIS COURT FOR DECISION

The fact that CMS has approved the underlying SPAs, and therefore the challenged payment reductions, does not affect the "live" nature of the controversy before this Court.

A. Under Respondents' Theory, SPA Approval Does Not Impact the Existence of a Supremacy Clause Cause of Action Against the State

Respondents have consistently taken the position, in oral argument and through their post-approval actions, that SPA approval has no impact whatsoever on the existence of a Supremacy Clause cause of action against a state whose Medicaid reimbursement rates purportedly conflict with § 30(A). At oral argument, counsel for respondents explained that, under respondents' theory, a Supremacy Clause cause of action would exist even were the SPAs approved by CMS:

JUSTICE ALITO: What about the agency approves rates and someone is dissatisfied with the rates sues and says these rates are ridiculously low?

MR. PHILLIPS: Oh, you can bring a lawsuit --

JUSTICE ALITO: They still can sue –

MR. PHILLIPS: -- Justice Alito. The -- the bottom line is you're going to lose that -- that litigation and in a circumstance where you have no realistic prospect of --

JUSTICE ALITO: Well, how do you know they're going to lose the litigation? Why should they lose the litigation if it's really -- if there really is a cause of action there? Some of the Medicaid rates are very low, aren't they?

MR. PHILLIPS: Well, ultimately, you they have to demonstrate that there's -- that there is a -- by clear and convincing evidence, a conflict between Federal and the State law. And the agency that has –that evaluates the standards of Federal law will have said in a very authoritative way that there is not a violation under those circumstances.

CHIEF JUSTICE ROBERTS: But you still have a cause of action under the Supremacy Clause.

MR. PHILLIPS: Oh, no, to be sure, I have a cause of action

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JUSTICE SCALIA: You've lost me here. You -- you say there would be a cause of action under the Supremacy Clause if the agency approves the rates, but your clients don't think the rates are high enough?

MR. PHILLIPS: Sure, we would still say there's a --

JUSTICE SCALIA: Under the --

MR. PHILLIPS: We would still have an argument that there's a conflict between Federal and State law.

JUSTICE SCALIA: Well, Federal law is determined by the agency, surely. So long as the agency is complying with the Administrative Procedure Act, I don't see how you have any --

MR. PHILLIPS: Well --

JUSTICE SCALIA: -- any cause of action under the Supremacy Clause; you may have an APA cause of action.

MR. PHILLIPS: Well, we -- well, the problem with the APA -- we might have an APA cause of action, but I also think that there is a -- I mean, I -- look, that hypothetical is so far afield

JUSTICE SCALIA: Federal law is not determined by the agency?

MR. PHILLIPS: I'm sorry, Justice Scalia.

JUSTICE SCALIA: Federal law is not determined by . . . the agency?

MR. PHILLIPS: No, of course, Federal law is determined by the agency --

JUSTICE SCALIA: Well, then you don't have a Supremacy Clause cause of action.

MR. PHILLIPS: Well, I think you -- I still think you can bring an action under the Supremacy Clause. I think, ultimately, you have very -- you have zero hope of prevailing --

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CHIEF JUSTICE ROBERTS: Why does the agency get to determine Federal law when Congress doesn't? You told me earlier if Congress –

MR. PHILLIPS: Because Congress --

CHIEF JUSTICE ROBERTS: -- Congress says in a statute no implied right of action, that that doesn't control.

MR. PHILLIPS: Right, but that doesn't -- that controls to the extent of trying to enforce directly the Federal statute; it doesn't control with respect to trying to enforce the Supremacy Clause.

Tr. of Proceedings at 52-56.

Respondents' recent actions have confirmed the view they advanced at oral argument. In the days following CMS's announcement, counsel for several of respondents here (Hooper, Lundy & Bookman, and Lynn S. Carman) filed two new lawsuits challenging some of the SPA approvals as to rate reductions not at issue in the present cases. Exs. B, C. Plaintiffs in those cases – who include many of respondents here[3] – assert both Supremacy Clause/§ 30(A) causes of action (against DHCS) and federal APA claims (against the Secretary of the United States Department of Health and Human Services (HHS)). Ex. B, at 34-37, 39-42; Ex. C, at 10-11. These lawsuits seek to proceed on the theory enunciated by their counsel at oral argument: that a Supremacy Clause cause of action exists whenever there is a conflict between federal and state law (plus standing to assert injury), and that SPA approval is irrelevant to its existence.[4] (Mr. Phillips' co-counsel apparently do not agree with him that a challenge to CMS's approval of a SPA has "zero hope of prevailing.")

Respondents' position at oral argument – that *if* a preemption cause of action may be stated here against the State, SPA approval may affect its merits but not its existence – appears to

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[3] Respondents who are also plaintiffs in the new cases include: the California Hospital Association; Independent Living Center of Southern California, Inc.; Gerald Shapiro, Pharm.D; Sharon Steen; Tran Pharmacy, Inc.; and Mark Beckwith.

[4] By contrast, petitioners contend that (1) *no* private cause of action exists as to § 30(A), a statute that does not confer any rights and that contains vague and undefined standards that are suited to administrative enforcement; (2) equitable relief is only available to redress breach of a "right," not merely an "injury," *see* 1 John Norton Pomeroy, *A Treatise on Equity Jurisprudence*, §§ 89-107 (3d ed. 1905) (enumerating the full panoply of "primary rights," the breach of which may give rise to an equitable "remedial right"); *see also Tenn. Elec. Power Co. v. Tenn. Valley Auth.*, 306 U.S. 118, 137 (1939); *Terrace v. Thompson*, 263 U.S. 197, 214 (1923); and (3) exercise of the Court's equitable powers is limited by its separation-of-powers jurisprudence, *see, e.g., Alexander v. Sandoval*, 532 U.S. 275, 286-87 (2001).

be correct. To be sure, a federal agency's interpretation of federal law that it administers is entitled to judicial deference, and may even be dispositive when its interpretations are challenged in court. *National Cable & Telecomm. Ass'n v. Brand X Internet Svcs.*, 545 U.S. 967 (2005) (*Brand X*); *Chevron, USA, Inc. v. Natural Res. Def. Council*, 467 U.S. 837 (1984). However, deference to a federal agency's interpretation of federal law goes to the merits of a cause of action, not its existence.

B. A Live Controversy Continues to Exist Between DHCS and Respondents

Nor is the case moot under the State's position. SPA approval, and DHCS's agreement to withdraw some requests for approval, have resolved some components of the parties' dispute. However, a live controversy continues to exist in all three petitions.

As explained in Part I, *supra*, and in the table attached as Exhibit A, there is no longer any dispute regarding some periods during which the payment reductions either were allowed to take effect (pre-injunction), or were not in effect because they were enjoined. This is largely because, in consultation with CMS, DHCS agreed to withdraw certain requests for retroactive SPA approval out of a concern for ensuring adequate beneficiary access to services.

DHCS did not, however, agree to withdraw all of its requests for SPA approval for periods in which rate reductions were enjoined. There remains a live controversy as to those rate reductions that were enjoined by a court, that CMS subsequently has concluded comply with federal law, including § 30(A), and as to which the State did not withdraw its request for SPA approval. Should this Court rule in DHCS's favor in the underlying petitions, those injunctions would be vacated. DHCS would then be in a position to seek recoupment of amounts paid to providers as a result of the injunctions, to the extent those payments exceeded the rates that CMS has now approved. *See* Cal. Welf. & Inst. Code §§ 14176, 14177; 22 Cal. Code. Regs. § 51458.1.

Specifically, the potential for such recoupment, based on SPA approval, exists as to most of the reductions at issue in the *California Pharmacists* and *Santa Rosa* petitions. *See* Ex. A, col. VI. This includes: (1) the AB1183 reduction applicable to hospital outpatient services over the period January 1, 2011 through April 12, 2011; (2) the AB1183 reduction applicable to distinct part skilled nursing facilities over the period March 1, 2011 through May 31, 2011; (3) the AB1183 reductions applicable to Adult Day Health Centers over the period March 1, 2011 through May 31, 2011; (4) the AB1183 reductions applicable to prescription drugs over the period March 1, 2011 through May 31, 2011; (5) the AB1183 reductions applicable to noncontract hospitals over the period January 1, 2011 through April 12, 2011; and (6) the AB5 reductions applicable to noncontract hospitals over the period January 1, 2011 through April 12, 2011.

Although the potential for recoupment by California of excess payments no longer exists as to the reductions at issue in the *Independent Living* petition, that petition continues to present a live controversy for a different reason. Specifically, unless this Court rules in its favor,

California anticipates that some providers in *Independent Living* will continue to press for additional, pre-injunction, retroactive reimbursement based on already pending motions for summary judgment that seek precisely that relief. The Ninth Circuit has already ordered retroactive reimbursement to *some* providers for *some* services, specifically those encompassed within the district court's order of August 18, 2008 in *Independent Living*, such as physicians, clinics, dentists, optometrists, adult day health care centers, and prescription drugs. *Indep. Living* Pet. App. 29-37. Following the Ninth Circuit's decision, respondents filed two separate motions for summary judgment that sought permanent injunctions of the AB5 reductions retroactive to July 1, 2008, and that included *other* providers and services for which retroactive relief previously had not been sought. C.D. Cal. No. 08-CV-03315, Docket Entry No. 376, at 2:5-12; C.D. Cal. No. 08-CV-03315, Docket Entry No. 370.[5] The district court has stayed these motions pending a decision from this Court. C.D. Cal. No. 08-CV-03315, Docket Entry No. 392.

The dispositions of the two stayed motions in *Independent Living* will depend on how this Court rules. If the Court adopts respondents' theory, they will be able to continue to prosecute their motions in an effort to obtain additional retroactive relief (notwithstanding, as noted above, the intervening SPA approvals). If, however, the Court rejects respondents' theory, the cases will be dismissed entirely, and the pending motions will never be decided.[6]

Some respondents may contend that the proper course is to remand the cases to the Ninth Circuit to reassess whether, in light of the SPA approvals, the injunctions should be vacated on their merits. And it is true that, under this Court's precedents, the Ninth Circuit would be required to exercise great deference both to CMS's interpretation of § 30(A) and its application

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[5] Those additional services include non-emergency medical transportation and home health agency services (at issue in the *Independent Living* petition), as well as hospital outpatient services (SPA approved for services rendered July 1, 2008-February 28, 2009); DP/NF (level B) services (SPA approved for services rendered July 1, 2008-February 28, 2009); DP/NF (subacute) services (SPA approved for services rendered July 1, 2008-February 28, 2009); durable medical equipment (SPA approved for services rendered July 1, 2008-February 28, 2009); and certain non-contract hospital inpatient services (SPA approved for services rendered July 1, 2008-April 12, 2011, except for 17 plaintiff hospitals in *Santa Rosa*, as to which it was approved for services rendered July 1, 2008-November 17, 2009, and January 1, 2011-April 12, 2011).

[6] Were the Court to determine, notwithstanding this discussion, that *Independent Living* is moot, then it could either hold *Independent Living* pending resolution of the other two petitions, or remand to the Ninth Circuit with directions to vacate its judgments and the underlying injunctions as moot, and to order the cases dismissed. Holding *Independent Living* pending a disposition in *California Pharmacists* and *Santa Rosa* would enable the Court to assess whether any dismissal should be with prejudice.

of the relevant statutory standards to the challenged reductions. *Brand X*, 545 U.S. 967; *Chevron*, 467 U.S. 837; *see also Chase Bank USA v. McCoy*, 131 S. Ct. 871 (2011). However, remand would preclude a judicial determination of the threshold question of whether a private cause of action even exists; if no cause of action exists, there would be no basis for the Ninth Circuit to use the pending cases as a vehicle to, in effect, collaterally review CMS's decision to approve the SPAs (as distinct from the proper vehicle, a lawsuit brought under, and governed by, the federal APA). Moreover, the Ninth Circuit has *in these cases* already expressly (and incorrectly) rejected CMS's interpretation of § 30(A), and expressly (and incorrectly) ruled that CMS's construction is not entitled to judicial deference. *Indep. Living* Pet. App. at 17. And finally, unless the Court decides the threshold "cause of action" question, the problems with permitting private enforcement of § 30(A) would persist: as long as private parties may invoke preemption theory to enforce § 30(A), the States will continue to be subject to the conflicting interpretations of federal law and the massive, but unpredictable, liability that Congress sought to avoid by centralizing enforcement in HHS. *See Astra USA, Inc. v. Santa Clara Cty.*, 131 S. Ct. 1342, 1349 (2011).[7]

Finally, the *California Pharmacists* petition continues to present a "live" controversy for another reason: the state statute challenged in *Dominguez* is unaffected by SPA approval. We note that, after the district court entered its injunction in *Dominguez*, the California Legislature acted to suspend the challenged state statute until, at the earliest, July 1, 2012, and then, only "if a court of competent jurisdiction has issued an order, that is not subject to appeal or for which the time to appeal has expired, upholding its validity," "in order to allow the litigation to reach a final result." Cal. Welf. & Inst. Code § 12306.1(d)(7)(A),(B).[8] A decision by this Court that § 30(A) is not privately enforceable would therefore eliminate one significant hurdle to obtaining the final judicial determination that this statute requires. (The district court would still have to rule on plaintiffs' other claims, including those brought under the Americans with Disabilities Act and the Rehabilitation Act.)

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[7] In a recently filed brief in one of their new lawsuits, respondents seek to enjoin some of the CMS-approved reductions expressly on the ground that the Ninth Circuit's interpretation of § 30(A) is correct; CMS's interpretation is incorrect; and the Ninth Circuit is not required to defer to CMS. *See* Ex. D, at 5-6; *see also* Ex. B, at 40:1-12 (arguing that HHS is bound by the Ninth Circuit's interpretation of § 30(A)); Ex. C at 11:16-21.

[8] *See also id.*, § 12306.1(d)(7)(A) ("The Legislature finds and declares that injunctions issued by the courts have prevented the state from implementing the changes . . . during the pendency of litigation. To avoid confusion for providers, recipients, and other stakeholders, it is therefore the intent of the Legislature to temporarily suspend the reductions . . . until July 1, 2012, to allow the litigation to reach a final result.").

For all the foregoing reasons, in addition to those mentioned in our briefs, petitioners request that the Court (1) hold that private parties may not bring a preemption claim to enforce § 1396a(a)(30)(A); (2) reverse or vacate the Ninth Circuit's judgments; and (3) direct the Ninth Circuit to vacate any injunctions and order the cases dismissed with prejudice.

Respectfully,

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I Case	II Cal. Statute(s)	III Services Affected	IV Dates Reduction Implemented Pre-Injunction, and SPA Approval Received	V Dates Reduction Not Implemented Due to Injunction, and Request for SPA Approval Withdrawn	VI Dates Reduction Not Implemented Due to Injunction, and SPA Approval Received	VII Current Status
Indep. Living (09-958)	AB5 Cal. Welf. & Inst. Code § 14105.19(b)(1) (10% reduction)	Physicians, Clinics, Dentists, Optometrists, Adult Day Health Centers, Prescription Drugs	N/A (Reduction enjoined retroactively to its effective date.)	7/1/08-2/28/09	N/A	Not in effect; legislation sunset 2/28/09.
	AB5 Cal. Welf. & Inst. Code § 14105.19(b)(1) (10% reduction)	Non-Emergency Medical Transportation, Home Health Services	7/1/08-11/16/08	11/17/08-2/28/09	N/A	Not in effect; legislation sunset 2/28/09.
Cal. Pharm (09-1158)	AB1183 Cal. Welf. & Inst. Code § 14105.191(b)(1) (1% reduction)	Hospital Outpatient Services	3/1/09-4/5/09	4/6/09-12/31/10	1/1/11-4/12/11	Not in effect because request for SPA approval withdrawn for all periods other than 3/1/09-4/5/09 and 1/1/11 to 4/12/11.
	AB1183 Cal. Welf. & Inst. Code § 14105.191(b)(2)(B) (5% reduction)	Hospital Distinct Part Nursing Services	3/1/09-4/5/09	4/6/09-2/28/11	3/1/11-5/31/11	Not in effect because legislation retroactively sunset on 6/1/11 upon recent SPA approval effective that date to pay 2008-09 rates reduced by 10%. *See* Cal. Welf. & Inst. Code §14105.192 (j),(o)(3).
	AB1183 Cal. Welf. & Inst. Code § 14105.191(b)(2)(D), (E) (5% reduction)	Hospital Distinct Part Subacute Services (Adult and Pediatric)	3/1/09-4/5/09	4/6/09-present	N/A	Not in effect because request for SPA approval withdrawn for all periods other than 3/1/09-4/5/09.

I Case	II Cal. Statute(s)	III Services Affected	IV Dates Reduction Implemented Pre-Injunction, and SPA Approval Received	V Dates Reduction Not Implemented Due to Injunction, and Request for SPA Approval Withdrawn	VI Dates Reduction Not Implemented Due to Injunction, and SPA Approval Received	VII Current Status
	AB1183 Cal. Welf. & Inst. Code § 14105.191(b)(2) (F) (5% reduction)	Adult Day Health Centers	3/1/09-3/8/09	3/9/09-2/28/11	3/1/11-5/31/11	Not in effect because legislation retroactively sunset on 6/1/11 upon recent SPA approval effective that date to pay 2008-09 rates reduced by 10%. *See* Cal. Welf. & Inst. Code § 14105.192(j),(o)(3).
	AB1183 Cal. Welf. & Inst. Code § 14105.191(b)(3) (5% reduction)	Prescription Drugs	N/A (This reduction was enjoined before it took effect.)	3/1/09-2/28/11	3/1/11-5/31/11	Not in effect because legislation retroactively sunset on 6/1/11 upon recent SPA approval effective that date of a 10% rate reduction. *See* Cal. Welf. & Inst. Code § 14105.192(d)(1),(o)(3).
	AB1183 Cal. Welf. & Inst. Code § 14166.245(b)(2)(A), (c)(3)(B) (CMAC-5% cap)	Non-Contracting Hospitals (Inpatient Services)	10/1/08-4/5/09	4/6/09-12/31/10	1/1/11-4/12/11	Not in effect because legislation sunset April 12, 2011. *See* Cal. Welf. & Inst. Code § 14166.245(j).
	SB6 Cal. Welf. & Inst. Code § 12306.1(d)(6) (cap on State's contribution to wages and benefits)	In-Home Supportive Services	N/A (This statute was enjoined before it took effect.)	7/1/09-present	N/A (This statute does not require SPA approval)	Could take effect on July 1, 2012 if the injunction is lifted. *See* Cal. Welf. & Inst. Code § 12306.1(d)(7).
Santa Rosa (10-283)	AB5 Cal. Welf. & Inst. Code § 14166.245(b), (c)(3) (10%, CMAC-5%)	Non-Contracting Hospitals (Inpatient Services)	7/1/08-11/17/09	11/18/09-12/31/10	1/1/11-4/12/11	Not in effect because legislation sunset April 12, 2011. *See* Cal. Welf. & Inst. Code § 14166.245(j).

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UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA, WESTERN DIVISION

CALIFORNIA HOSPITAL ASSOCIATION; DOES 1-5, Plaintiffs, vs. TOBY DOUGLAS, Director of the State Department of Health Services, State of California; KATHLEEN SEBELIUS, Secretary of the United States Department of Health and Human Services, Defendants.	CASE NO. **COMPLAINT FOR INJUNCTIVE AND DECLARATORY RELIEF**

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JURISDICTION AND VENUE

1. Plaintiffs, the California Hospital Association ("CHA") and Does 1-5, brings this complaint pursuant to 28 United States Code ("U.S.C.") § 1331, the Supremacy Clause, 42 U.S.C. § 1983 and the Administrative Procedure Act ("APA), as codified at 5 U.S.C. § 706, *et. seq. Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 96 n. 14 (1983). This court further may compel Defendant Toby Douglas, Director of the California Department of Health Care Services (the "Director") and Kathleen Sebelius, Secretary of the United States Department of Health and Human Services ("Secretary"), to comply with the mandatory provisions of the federal Medicaid law pursuant to 28 U.S.C. § 1361.

2. Venue lies in this judicial district under 28 U.S.C. § 1391, in that the Director has offices within this judicial district and is thus deemed to reside within this judicial district and also in that plaintiffs or their members are located and reside within this judicial district and the consequences of Defendants' unauthorized and arbitrary activities are occurring within this judicial district.

INTRODUCTION

3. The State of California is set to unleash a reduction of unprecedented magnitude in the rates at which hospitals are compensated under the State's Medicaid program, Medi-Cal, for providing skilled nursing care to Medi-Cal beneficiaries. Once effective, this latest reduction will result in hospitals getting in *excess of twenty percent less* than what they currently are being paid for furnishing the impacted services. This "mega" rate reduction is remarkable for many reasons, but one in particular is that it represents the resurrection of multiple prior rate reductions and limitations that were previously promulgated by the State, but found to be in violation of the federal Medicaid Act. Apparently wholly undeterred by what this court, and the Court of Appeal for the Ninth Circuit says the Medicaid Act requires, the State has not only brought back those prior limitations, which

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significantly reduce payments, but is adding an additional 10 percent reduction on top of them. Add to that the fact that a California Court of Appeal has determined that the entire methodology for how the payment rates in question are determined in the first place is invalid under federal law and artificially reduces provider payments. In short, with the action being challenged here, the State has effectively rolled three unlawful cuts and limitations into one, and then cut the rates even further for good measure, all in the name of budgetary savings.

4. Somewhat miraculously, notwithstanding the sordid history behind the rate reduction at issue, the federal agency charged with administering the Medicaid program, the Centers for Medicare and Medicaid Services ("CMS"), has found that the reduction is consistent with Medicaid Act requirements and, in particular, poses no risk that Medi-Cal beneficiary access to skilled nursing services will be impacted. Aside from being wholly inconsistent with governing case law concerning what the Medicaid Act requires, CMS' decision simply defies reason and logic. It strains credulity to its breaking point to accept that the State could take rates that, from the outset, are skewed against providers, then reduce them by 10 percent, then not adjust the rates to reflect increased provider costs over a period of three years and then reduce them by another 10 percent, all without having any adverse impact on provider participation levels in Medi-Cal. Nevertheless, as discussed below, that is effectively what CMS determined.

5. By this action, an organization representing the interests of California hospitals seeks an injunction to invalidate and stop the implementation of this latest "mega" cut to the rates paid under Medi-Cal for hospital based skilled nursing services. On the most immediate level, this new payment reduction will improperly deprive Medi-Cal participating hospitals of reimbursement to which they otherwise are lawfully entitled. However, contrary to what the State and CMS have determined, and even more alarmingly, this massive payment reduction will almost immediately threaten the ability of many hospitals to continue to operate skilled

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nursing units. When these units are forced to close, it will, at worst, create significant gaps in access to such services for Medi-Cal beneficiaries, particularly those residing in already medically underserved, rural areas and, at best, cause significant delay in patients obtaining needed services. Moreover, when hospital-based skilled nursing care becomes unavailable in many areas, it will likely result in some patients who are in need of the level of nursing care provided in these types of facilities being forced to remain in more expensive, acute care settings or being transferred to freestanding nursing facilities, which are less qualified to provide the care they need.

6. As were its predecessors, this latest budget driven reduction for hospital based skilled nursing care is contrary to federal law and numerous rulings by this Court and the Ninth Circuit Court of Appeals concerning the obligations imposed by the Medicaid Act. Further, when operating in conjunction with California State laws that place restrictions on the ability of skilled nursing facilities to close outright or withdraw from Medi-Cal, the rate reductions are going to effectively seize the private property of hospitals without adequate compensation in violation of the respective Takings Clauses of the United States and California Constitutions.

7. Consistent with the foregoing, Plaintiffs seek declaratory and injunctive relief to prevent the State of California from implementing and/or enforcing this unlawful, enormous payment reduction and setting aside CMS' approval of it.

THE PARTIES

8. Defendant TOBY DOUGLAS is the Director of the Department of Health Care Services and as such, has the responsibility to administer the Medi-Cal program consistent with the federal Medicaid Act. The Director is sued in his official capacity. The Department is the single state agency charged with the administration of California's Medicaid program, known as Medi-Cal. *See* California Welf. & Inst. Code §§ 14000 *et seq.* The Director has an office in the

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County of Los Angeles.

9. Defendant KATHLEEN SEBELIUS, the Secretary of the United States Department of Health and Human Services ("Secretary"), is the federal officer responsible for administering the Medicaid program at the federal level. The Secretary, through her designated agent, the Centers for Medicare and Medicaid Services ("CMS"), is responsible for reviewing and approving policy changes that states make to their Medicaid program. The Secretary has approved the policy changes that California has made to Medi-Cal, which Plaintiff is challenging herein.

10. Plaintiff CHA is a trade association representing the interests of hospitals in the State of California. CHA is incorporated in the State of California with its principal office in Sacramento, California. CHA's member hospitals provide both inpatient and outpatient hospital services. Many of CHA's members operate skilled nursing facilities that are distinct part units within the hospital, commonly referred as "DP/NFs." Many CHA members that operate DP/NFs, including privately owned hospitals, participate in Medi-Cal and provide skilled nursing care to needy Medi-Cal beneficiaries. CHA represents nearly 450 hospitals and health systems throughout California, including general acute care hospitals both small and large, children's hospitals, rural hospitals, psychiatric hospitals, academic medical centers, county and other public hospitals, investor-owned hospitals, privately owned non-profit hospitals and multi-hospital health systems. These hospitals furnish vital health care services to millions of the State's citizens. CHA brings this action on its own behalf and in its representative capacity on behalf of its members, many of which are providers of DP/NF services under California's Medi-Cal program and will be directly and adversely affected by the challenged rate limitations, and on behalf of its members' patients.

11. Plaintiffs DOES 1-5 are individuals residing in the State of California. Plaintiffs Does 1-5 are beneficiaries of the Medi-Cal program who require skilled nursing services. These individual Medi-Cal beneficiary plaintiffs have been

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receiving DP/NF services from hospitals that are CHA members and have been and/or will be adversely affected by the Medi-Cal payment rate reductions at issue in this action, to the extent those reductions will cause the DP/NFs at which these patients are currently residing to close or otherwise limit services.

FEDERAL MEDICAID LAW

12. Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 *et seq.*, the Medicaid Act, authorizes federal financial support to states for medical assistance to low-income persons who are aged, blind, disabled, or members of families with dependent children. The program is jointly financed by the federal and state governments and administered by the states. The states, in accordance with federal law, decide eligible beneficiary groups, types and ranges of services, payment level for services, and administrative and operative procedures. Payment for services is made directly by states to the individuals or entities that furnish the services. 42 Code of Federal Regulations ("C.F.R.") § 430.0.

13. In order to receive matching federal financial participation, states must agree to comply with the applicable federal Medicaid law and regulations, 42 U.S.C. §§ 1396 *et seq.* Once a state has decided to participate in the Medicaid program, compliance with the federal Medicaid law and regulations is mandatory.

14. At the state level, the Medicaid program is administered by a single state agency, which is charged with the responsibility of establishing and complying with a state Medicaid plan (the "State Plan") that, in turn, must comply with the provisions of applicable federal Medicaid law. 42 U.S.C. § 1396a(a)(5) and 42 C.F.R. §§ 430.10 and 431.10. The State Plan must be submitted to the Secretary of the United States Department of Health and Human Services (the "Secretary") for approval and must describe the policies and methods to be used to set payment rates for each type of service included in the state Medicaid plan. 42 C.F.R. §§ 430.10 and 447.201(b). Under federal Medicaid law, as interpreted by the Court of Appeals

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for the Ninth Circuit, Changes to the State Plan may not be implemented by the state prior to being approved by the Secretary.

15. The Secretary's review and approval of any Medicaid state plan amendment as satisfying the requirements of the Medicaid Act is reviewable under the APA, 5 U.S.C. § 706, *et seq.* Under the APA, agency action may be set aside where it is found to be arbitrary and capricious, an abuse of discretion or otherwise unsupported by substantial evidence. Among other things, an agency acts arbitrarily and capriciously when it fails to follow governing law with respect to a particular decision or action. Further, to comply with the APA, the Secretary must develop a record demonstrating adequate consideration of the relevant factors and a rational basis for her decision on the relevant SPA.

16. Each state's Medicaid plan must provide that "medical assistance" will be furnished *with reasonable promptness* to all eligible individuals. 42 U.S.C § 1396a(a)(8) ("Section (a)(8)").

17. Each state's Medicaid plan must "provide such safeguards as may be necessary to assure that... care and services will be provided [] in a manner consistent with... *the best interests of the recipients*." 42 U.S.C. § 1396a(a)(19) ("Section (a)(19)").

18. Each state's Medicaid plan must "provide such methods and procedures . . . relating to the utilization of, and the payment for, care and services available under the plan which may be necessary . . . *to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general public in the geographic area . . . .*" 42 U.S.C. § 1396a(a)(30)(A) (hereinafter "Section 30(A)") (emphasis added); 42 C.F.R. § 447.204. Section 30(A) has been interpreted by the Ninth Circuit Court of Appeals to require state Medicaid agencies to consider provider costs, based on "reasonable cost" studies, when setting Medi-Cal payment

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rates and to preclude states from basing Medicaid rate setting decisions solely on budgetary factors. Further, as interpreted by the Ninth Circuit Court of Appeals, Section 30(A) requires that the rates paid by a Medicaid program for services must bear a reasonable relationship to the costs that an efficiently and economically operated provider incurs in rendering such services.

CALIFORNIA'S MEDI-CAL PROGRAM

19. The State of California has elected to participate in the Medicaid program. California has named its program "Medi-Cal." *See* Cal. Welf. & Inst. Code §§ 14000 *et seq.*; 22 Cal. Code of Regs. ("C.C.R.") §§ 50000 *et seq.*

20. Medi-Cal healthcare payments are disbursed in two ways. The first is a "fee for service" process whereby the Department of Health Care Services (the "Department" or "DHCS") determines whether the healthcare services were covered and furnished to an eligible beneficiary, and, if so, pays the service providers directly. Alternatively, the Department administers Medi-Cal through various managed care models operated by public and private entities under contract. This action concerns only payments made under the fee-for-service component of the Medi-Cal program.

21. The Medi-Cal program covers skilled nursing care provided to eligible Medi-Cal beneficiaries, provided certain requirements are met. 22 C.C.R. § 51335. For Medi-Cal purposes, a skilled nursing level of care is defined as "the level of care needed by Medi-Cal beneficiaries who do not require the full range of health care services provided in a hospital as acute care or hospital extended care, but who require the continuous availability of skilled nursing care provided by licensed registered or vocational nurses." 22 C.C.R. § 51124(b). Medi-Cal covered skilled nursing care can be furnished in any institution that is licensed by the State as skilled nursing facility, including a distinct part unit of a hospital. 22 C.C.R. § 51121. As mentioned above, skilled nursing facilities that are hospital units are

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commonly referred to in the Medi-Cal context as "DP/NFs." In contrast, nursing facilities that are not hospital based are known as "freestanding SNFs."

22. Due to the type of patients that generally required skilled nursing care, in addition to other factors, a significant portion of funding provided to many skilled nursing facilities, both DP/NF and freestanding SNFs, comes from the Medi-Cal program. As a result, many of these facilities are highly dependent on the Medi-Cal program for their funding and financial survival.

23. Notably, although both DP/NFs and freestanding SNFs can furnish Medi-Cal covered skilled nursing care, on a general level, there are significant differences in the types of patients treated, and care provided, between these two classes of facilities, such that the two types of facilities are not interchangeable . In particular, patients treated in DP/NFs often present more complex medical issues and require more resources, including highly skilled nursing care and ancillary services, than do patients treated freestanding SNFs. Accordingly, in many cases, freestanding SNFs cannot, or are not available to, provide care to more complex patients that is equivalent to the care that would be rendered in a DP/NF.

MEDI-CAL PAYMENTS TO HOSPITALS FOR SKILLED NURSING CARE

24. Payments from the Medi-Cal fee for service program to hospitals are governed by various statutes, regulations, the State Plan, and in some instances, informal handbooks, manuals or bulletins.

25. Payments for services provided by DP/NFs are governed by 22 C.C.R. § 51511 and Attachment 4.19-D to the State Plan. Reimbursement is the lower of (1) a per diem rate based on a particular hospital's projected costs of providing DP/NF services, based on prior year data or (2) a statewide per diem "median" rate computed by the Department. Under the State Plan, the Department is required to re-evaluate Medi-Cal payment rates for DP/NF services on a yearly basis. The

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Department generally is required to make updates to payment rates each year to account for certain economic conditions in the industry, which reflect an assumption that provider costs will generally increase every year due to, at minimum, inflation.

THE STATE'S REPEATED UNLAWFUL REDUCTION OF DP/NF PAYMENT RATES

26. Since the late 1990s, the State of California has repeatedly engaged in efforts to freeze, reduce or otherwise limit the rates of reimbursement paid to DP/NFs under Medi-Cal. Most of these measures have been subject to legal challenge and found to be unlawful, or likely unlawful, under the Medicaid Act. Nevertheless, the State is effectively incorporating all these prior limits and reductions into rate cut at issue in this action.

27. Commencing with the 1995-1996 Medi-Cal rate year, the Department adopted a regulation that altered the methodology for computing per diem reimbursement rates for DP/NFs. Specifically, the regulation establishes that, in calculating the DP/NF payment median for any given year, which is a ceiling on the payment rates, the Department excludes consideration of cost data from DP/NF providers that, on average, have a Medi-Cal patient utilization of less than 20 percent, that is, the percentage of Medi-Cal patient days in the DP/NF is less than 20 percent of the DP/NF's total patient days. This "exclusion methodology" artificially decreases per diem payment rates and that, absent application of this methodology, payment rates for all Medi-Cal participating DP/NFs would be higher.

28. The "exclusion methodology" has been subject to multiple court challenges. Most recently, Plaintiff CHA challenged, through a writ of mandate proceeding in California State court, the Department's application of the exclusion methodology in the calculation of DP/NF reimbursement rates for all Medi-Cal rate years between 2000-2001 and 2005-2006. CHA alleged in that case that the exclusion methodology was invalid under Section 30(A) because, both in originally

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adopting the exclusion methodology and applying in the rate years at issue therein, the Department never appropriately considered whether the payment rates resulting from the exclusion methodology were reasonably related to costs and consistent with efficiency and economy of care. CHA also alleged that the fundamental assumption underlying the exclusion methodology, *e.g.*, that facilities which do not treat a high number of Medi-Cal beneficiaries have "inflated" costs, was untested, unsupported by relevant data and substantively incorrect.

29. In 2010, a California Court of Appeal agreed with CHA in a published opinion in which it declared that the exclusion methodology was invalid as not consistent with Section 30(A). *See California Hospital Ass'n v. Maxwell-Jolly*, 188 Cal. App.4th 559, 115 Cal. Rptr.3d 572 (Cal. Ct. App. 2010). The Court of Appeal remanded the case back to the State superior court for further proceedings consistent with its opinion, but did not order the Department to stop applying the exclusion methodology (and those proceedings are currently pending). Consequently, the exclusion methodology remains a component of the Department's rate setting process for DP/NFs.

30. In early 2008, through Assembly Bill X4 5 ("2008 AB 5"), the California Legislature mandated a flat ten percent reduction in the rates of reimbursement paid to, among other classes of facilities, DP/NFs. This reduction, which was effectuated through the enactment of Welfare & Institutions Code 14105.19, went into effect for services rendered on or after July 1, 2008. CHA joined with a coalition of other provider associations to challenged the 2008 AB 5 reimbursement reduction as being in conflict with, among other Medicaid Act provisions, Section 30(A). The litigation concerning the 2008 AB 5 payment reductions ultimately culminated in a published Ninth Circuit decision affirming a district court order enjoining the Department from applying the rate reduction to most classes of impacted providers. In *Indep. Living Ctr. Of S. Cal., Inc. v. Maxwell-Jolly*, 572 F.3d 644 (9th Cir. 2009) [hereinafter "*ILC II*"], the Ninth Circuit

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affirmed the district court 's determination that the plaintiffs in the case were likely to prevail on their claim that 2008 AB 5 was not enacted in accordance with, and therefore is preempted by, Section 30(A) because the State Legislature enacted the rate cut for purely budgetary reasons, without consideration of reliable cost studies or analysis of the potential impact of the rate reductions on beneficiary access to care.

31. The 2008 AB 5 rate reductions were never enjoined with respect to any classes of hospital services, including services rendered in DP/NFs, because the district court determined that hospitals did not demonstrate irreparable harm resulting from the rate reduction in the form of reduced Medi-Cal beneficiary access to hospital services. Neither CHA or any other plaintiff representing the interests of hospitals appealed this conclusion by the district court.

32. On September 18, 2008, after a protracted budget stalemate, then Governor Schwarzenegger signed Assembly Bill 1183 ("AB 1183"), the budget trailer bill for fiscal year 2008-09. AB 1183 amended Welfare and Institutions Code § 14105.19, making most aspects of the 2008 AB 5 rate reductions effective only through February 29, 2009, including rate cuts for DP/NF services. However, through the enactment of Welfare and Institutions Code § 14015.191, AB 1183 mandated a five percent rate reduction for Medi-Cal fee-for-services benefits paid to, among other facilities, DP/NFs, effective for services rendered on or after March 1, 2009.

33. On January 29, 2009, a coalition of Medi-Cal providers and provider organizations, including CHA, filed a complaint in district court against the Director challenging the AB 1183 Rate Reductions on the grounds that AB 1183 was not enacted in accordance with the requirements of the Medicaid Act, including those set forth in Section 30(A). On February 11, 2009, CHA and other individual hospital plaintiffs filed a motion in the district court seeking a preliminary injunction to prohibit implementation of the AB 1183 rate cuts for hospital services.

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34. On March 9, 2009 the district court issued an order denying the hospital plaintiffs' injunction motion concerning the AB 1183 rate reductions. Although the district court concluded that the hospital plaintiffs demonstrated a substantial likelihood of prevailing on their claims that the AB 1183 rate reductions conflicted with, and therefore are preempted by, Section 30(A), the court concluded there was not a demonstration that hospitals would be irreparably harmed by the reduced payment rates by virtue of the fact beneficiary access to hospital services would be reduced as a result of the rate reductions. In reaching this decision, the district court rejected an argument by CHA and the other hospital plaintiffs that hospitals necessarily were irreparably harmed by the AB 1183 rate reductions because they are precluded by the Eleventh Amendment from obtaining retroactive compensation from the State in federal court for any under-reimbursement.

35. CHA and the other hospital plaintiffs appealed the district court's order on March 11, 2009. The next day, they filed an emergency motion with the Ninth Circuit seeking a temporary stay of the AB 1183 rate reductions for hospitals on the grounds that the district court committed legal error by not finding that hospitals were faced with irreparable harm by virtue of reduced Medi-Cal payment rates.

36. The emergency motion was granted in a published decision from the Ninth Circuit. *See California Pharmacists Ass'n v. Maxwell-Jolly*, 563 F.3d 847 (9th Cir. 2009) ("*Cal. Pharm. I*"). In *Cal. Pharm. I*, the Ninth Circuit concluded that the plaintiffs showed that AB 1183 likely was preempted by Section 30(A) because the statute, and the Medi-Cal rate cuts called for thereby, were enacted without consideration of efficiency, economy, quality of care and the impact on beneficiary access to services. *Id.* at 851. *Cal. Pharm. I* also establishes that, for preliminary injunction purposes, unlawfully reduced Medi-Cal reimbursement constitutes an injury to the providers subject to the decreased rates and that such an injury is irreparable when, due to sovereign immunity, the reimbursement differential cannot be recovered in federal court. *Id.* at 851 - 853.

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37. Based on the aforementioned findings, the *Cal. Pharm. I* court stayed the AB 1183 rate reductions impacting hospitals, including DP/NFs. Subsequently, in a memorandum opinion, and relying on the same rationale set forth in *Cal. Pharm. I*, the Ninth Circuit reversed the district court's decision denying the hospital plaintiffs an injunction of the AB 1183 rate reductions and remanded the matter back to the district court for issuance of such an injunction order. Accordingly, on April 16, 2010, the district court issued an order enjoining the Department from applying the 5 percent reduction called for by AB 1183 to hospital services, including those rendered by DP/NFs. As of the filing of this Complaint, that injunction remains in effect.

38. On July 28, 2009, after four extra legislative sessions, then Governor Schwarzenegger signed into law Assembly Bill X4 5 ("2009 AB 5"), the budget trailer bill for California fiscal year 2009 – 2010. Although, unlike the last two California budget trailer bills, 2009 AB 5 did not make any flat percentage reductions to Medi-Cal payment rates, the bill enacted or amended multiple statutes in order to limit Medi-Cal reimbursement for several classes of hospital services.

39. 2009 AB 5 amended Welfare and Institutions Code § 14105.191 to effectively "freeze" the Medi-Cal payment rates for, among other things, DP/NFs at 2008 – 2009 levels. Specifically, the statute, as amended by 2005 AB 5, now provides that, for the designated services, "reimbursement rates . . . for services rendered during the 2009 – 10 rate year and each rate year thereafter, shall not exceed the reimbursement rates that were applicable to those classes of providers in the 2008-09 rate year." In effect, the amended version of the statute indefinitely suspends the annual payment updates for these classes of services that are otherwise required by the State Plan.

40. CHA initiated a challenge to the 2009 AB 5 rate limitations in November 2009. In *California Hospital Association v. Maxwell-Jolly*, Case No. 09-08642, by order dated February 24, 2010, the United States District Court for the

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Central District of California preliminarily enjoined the Director from applying or otherwise enforcing the 2009 AB 5 reimbursement limitations with respect to, among other things, DP/NF services based on findings that 2009 AB 5 was enacted by the Legislature without adherence to the requirements of Section 30(A) and that hospitals were being irreparably harmed by the decreased Medi-Cal reimbursement resulting from the limitation, which could not be recovered in an action for damages due to the State's Eleventh Amendment immunity. That injunction order remains in effect.

ASSEMBLY BILL AB 97 OF 2011

41. On March 25, 2011, Governor Brown signed into law Assembly Bill 97 of 2011 ("AB 97"), the health budget trailer bill for California fiscal year 2011 – 2012. As it has done so often in recent years, with AB 97, the State of California once again enacted significant payment reductions for many classes of services provided under the Medi-Cal program.

42. Most significantly for the present action, AB 97 enacts Welfare and Institutions Code § 14105.192, which authorizes the Director to reduce the Medi-Cal payment rates for various categories of services, effective June 1, 2011. Most of the rate reductions called for in the statute are simple, flat 10 percent reductions. However, pursuant to Section 14105.192(j), reimbursement for certain services "shall not exceed the reimbursement rates that were applicable to those classes of providers in the 2008-09 rate year, as described in subdivision (f) of Section 14105.91, reduced by 10 percent." Among the services impacted by this provision, are DP/NF services. (Curiously, there is no Section 14105.91 in the Welfare and Institutions Code. It appears that the Legislature intended to refer either to Section 14105.19 or section 14105.191 in AB 97).

43. Notwithstanding the difficulty in tracking the reference to Section 14105.91 in Section 14105.192(j), Plaintiffs are informed and believe and thereon

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allege, that the Department will apply Section 14105.192(j) to limit DP/NF payment rates to the rates in effect as of August 1, 2008, less 10 percent of those already reduced rates. Plaintiffs are informed and believe and thereon allege that such an application of the statute will result in an aggregate effective payment reduction in DP/NF rates of between 23 and 28 percent.

44. Pursuant to Section 14105.192(m), the reductions in Section 14105.192 cannot be implemented until the Director determines they are consistent with federal law. Pursuant to Section 14105.192(n), the Director is required to seek any federal approvals necessary to implement section 14105.192. Pursuant to section 14105.192(o), the Director may not implement any of the reductions in section 14105.192 "until federal approval is obtained." However, the statute provides that once federal approval is obtained, the reductions may be implemented retroactively as of June 1, 2011.

45. Plaintiffs are informed and believe and thereon allege that, prior to giving DHCS the authority to reduce DP/NF payment rates pursuant to Section 14105.192, the California Legislature did not conduct or commission any reliable cost studies to determine whether the altered payment rates would be consistent with efficiency, economy, quality of care, sufficient to ensure continued adequate access to care for Medi-Cal beneficiaries or reasonably related to the costs hospitals incur in furnishing the DP/NF services. Rather, all the rate reductions called for by AB 97, including the reductions in DP/NF rates, were enacted by the Legislature for solely budgetary purposes.

46. The Medi-Cal payment rate reduction called for by AB 97, as codified at Section 14015.192, for services rendered by DP/NFs shall be referred to hereinafter as the "2011 DP/NF Rate Reduction."

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FEDERAL APPROVAL OF THE 2011 DP/NF RATE REDUCTION

47. Consistent with the terms of Section 14105.192, DHCS submitted a proposed State Plan Amendment or "SPA" to CMS on June 30, 2011, which sought federal approval of the 2011 DP/NF Rate Reduction and incorporation of that reduction into California's Medi-Cal State Plan.

48. According to information that Plaintiff CHA received from the State, at the time the proposed SPA concerning Section 14105.192, designated by DHCS as 11-010, was submitted to CMS, it was not accompanied by any materials purporting to evaluate whether the proposed rate reduction was consistent with the requirements of the Medicaid Act other than "interim drafts of portions of an access analysis."

49. In July 2011, through a request submitted under California's Public Records Act ("PRA"), as codified at California Government Code §§ 6250, *et seq.*, Plaintiff CHA sought all materials submitted by DHCS to CMS in connection with SPA 11-010, as well as other concurrently submitted SPAs. CHA made this request so that it could review and evaluate the materials the Department submitted to CMS in support of, among other things, the 2011 DP/NF Rate Reduction and, if necessary, provide additional relevant information to CMS in response to the State's submission that would be relevant to CMS' evaluation of the SPAs in question, including SPA 11-010.

50. On July 26, 2011, DHCS responded to CHA's PRA request and indicated that there were no responsive materials other than the SPA documents themselves. The letter further advised that DHCS would not provide CHA with access to the "interim drafts of portions of an access analysis" that were submitted to CMS in conjunction with SPA 11-010 on the ground that those materials were not subject to disclosure under the PRA due to a "Deliberative Process Privilege."

51. At the same time CHA was seeking materials from DHCS concerning the SPA on the 2011 DP/NF Rate Reductions, it was also communicating with CMS

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concerning the State's efforts to get two other SPAs concerning a previously enacted DP/NF rate limitations approved. Those limitations, which are discussed above, called for first, a 5 percent reduction in DP/NF rates effective March 1, 2009, and then a suspension in any annual updates to DP/NF rates, effective August 1, 2009. In July 2011, CHA provided extensive information to CMS concerning why the SPAs for the 2008 and 2009 DP/NF payment limitations should not be approved. CHA's submission, which included data analysis from an reimbursement expert, explained that, among other things: (1) low Medi-Cal reimbursement rates were already starting to lead to the closure of DP/NF facilities; (2) Medi-Cal beneficiaries already were starting to experience difficulties in accessing skilled nursing care, including significant delays in transferring from the hospital setting to freestanding SNFs; and (3) that, even before application of the reductions at issue in the SPAs, DP/NFs were already being reimbursed by Medi-Cal at rates significantly below their costs. In short, CHA presented extensive data to CMS showing that, even without application of the 2011 DP/NF Rate Reduction, the State's payment policies for DP/NF were creating access problems for beneficiaries with respect to skilled nursing services.

52. By later dated August 11, 2011, CHA notified CMS about how DHCS declined to turn over materials related to SPA 11-010 and others in response to CHA's public records request. In the letter, CHA questioned how it would be possible for CMS to conduct a full and adequate review of SPA 11-010 if DHCS had not yet submitted complete and final information to CMS about the probable impact of the relevant rate cut on, among other things, beneficiary access to services. CHA also reiterated that it was critical to the hospitals that the association represents that it be afforded an opportunity to review and comment on the materials DHCS submitted in support of the proposed rate reductions, including the 2011 DP/NF Rate Reduction. Accordingly, in the letter, CHA requested, under the federal Freedom of Information Act ("FOIA"), that CMS disclose all materials

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exchanged between DHCS and CMS concerning, among other things, SPA 11-010. That same day, CHA received a form letter from CMS in response to the FOIA request, which indicated in vague terms that the request was being processed.

53. In September 2011, in conjunction with the various SPAs pending concerning limitations on DP/NF payment rates, particularly the 2011 DP/NF Rate Reduction, CHA commissioned a "Special Report" concerning Medi-Cal beneficiary access to skilled nursing care. This report was prepared by an independent third party consultant and, in general, concludes that Medi-Cal beneficiary access to hospital based skilled nursing care was already suffering under then-existing Medi-Cal rates and would only decrease further if additional payment rate reductions were implemented. The Special Report also explains in detail the unique role that DP/NFs play in the patient care continuum, including a discussion of why DP/NF care is not interchangeable with care provided in freestanding SNFs. This Special Report was provided initially to CMS on September 14, 2011.

54. On September 27, 2011, while CHA was still awaiting meaningful responses from either DHCS or CMS to the PRA and FOIA requests, respectively, it has submitted concerning SPA 11-010, CMS issued a letter to DHCS, which responded to the SPA by asking DHCS to submit additional information concerning the proposed rate reduction. This Request for Additional Information ("RAI") was fairly extensive and included a list of sixteen inquiries that CMS felt DHCS needed to address in order to allow CMS to appropriately assess whether the rate reduction called for in the SPA 11-010 would be consistent with the Medicaid Act.

55. During the week of October 13, 2011, CHA received from CMS materials related to SPA 11-010 that had been previously submitted by DHCS. Those materials did not include any information that DHCS submitted directly to CMS in response to the September 27, 2011 RAI. In conjunction with receipt of this information, CHA sent CMS a letter urging the agency to delay consideration of SPA 11-010 in order to allow CHA to review and comment on the documentation

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that DHCS had submitted to CMS in support of the rate reductions. As part of that request, CHA also indicated that it wanted an opportunity to review whatever additional information DHCS submitted to CMS in response to the RAI. CHA noted that it was critical it be afforded this opportunity because the 2011 DP/NF Rate Reduction was likely to have an unprecedented adverse impact on California hospitals and the Medi-Cal program as a whole.

56. On October 27, 2011, CHA submitted a letter to CMS addressing the materials DHCS had submitted to CMS in support of SPA 11-010 prior to the September 27, 2011 RAI. As of the time of the preparation of the October 27, 2011 letter, CHA had not received from either CMS or DHCS any materials that DHCS has prepared specifically in response to the RAI. CHA's October 27, 2011 letter to CMS explained in detail why any purported studies DHCS had conducted with respect to whether the 2011 DP/NF Rate Reduction would be consistent with Medicaid Act requirements were "woefully" inadequate. CHA pointed out that DHCS' assessment of the impact that the rate reduction would have on beneficiary access to skilled nursing services was based on skewed and incomplete data and on the fundamentally flawed assumption that the services rendered by DP/NFs and freestanding SNFs are essentially fungible. In addition, among other things, CHA also pointed out that DHCS' analyses failed to address the significant geographical differences in terms of access to skilled nursing care as between rural and non-rural areas. Finally, CHA noted that DHCS analyses were devoted exclusively to assessing the impact of the 2011 DP/NF Rate Reduction on access and did not at all consider the impact of the rate reduction on qualify of services and questions of efficiency, which are also relevant factors under the Medicaid Act. The entire discussion in CHA's October 27, 2011 proved to be for naught, however, since CMS's decision on SPA 10-010 had already been made.

57. By letter dated October 27, 2011, CMS provided notice that it was approving SPA 11-010, including the 2011 DP/NF Rate Reduction, The SPA

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approval letter indicated that CMS' decision was based on the fact that the "State was able to provide metrics which adequately demonstrated beneficiary access." Those "metrics" included information about "total numbers of providers by type and geographic location" participating in Medi-Cal, "total number of Medi-Cal beneficiaries by eligibility type," and "utilization of services over time." CMS also indicated that it accepted DHCS' plan to monitor access to services going forward. There is no reference in the October 27, 2011 letter from CMS approving SPA 11-010 to any considerations of the impact of the 2011 DP/NF Rate Reduction on quality of care or efficiency.

58. Plaintiffs are informed and believe and thereon allege that, given that CMS has approved the SPA, DHCS imminently intends to start applying the new limitation to DP/NF payments, including through the retrospective recovery of purported "overpayments" for services rendered on or after June 1, 2011 that were paid at the unreduced rate in effect during that period.

THE ILLEGALITY OF 2011 DP/NF RATE REDUCTION

59. Violation of the United States and California Constitutions, Takings Clause: California law places restrictions on the ability of participating skilled nursing facilities, including DP/NFs, to both withdraw from Medi-Cal and cease operations. *See, e.g.* Cal. Health & Safety Code § 1336.2 and Cal. Welf. & Inst. Code § 14022.4. Such facilities are not permitted to immediately stop treating patients, but rather must take extensive steps to ensure that their patients are transferred to other patient facilities. However, in some instances, this class of facilities may be required, by statute, to continue treating particular patients who refuse transfer to other facilities. Along these longs, skilled nursing facilities may only effectively withdraw from the Medi-Cal program when all Medi-Cal patients have left the care of the facility. California law therefore compels skilled nursing facilities, including DP/NFs, to furnish services to Medi-Cal beneficiaries for at

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least a certain period of time, which constitutes an appropriation of these facilities and a taking of their private property by the State of California. Due to the outrageously low rates at which the Medi-Cal program will compensate DP/NFs after the 2011 DP/NF Rate Reduction goes into effect, Plaintiff CHA's members that operate DP/NFs will not be justly compensated by the State for their property in violation of the Fifth and Fourteenth Amendments of the United States Constitution and Section 19, Article I of the California Constitution.

60. Violation of Federal Statute: The 2011 DP/NF Rate Reduction is invalid and may not lawfully be implemented because they violate federal Medicaid law, and are therefore preempted by the Supremacy Clause, because:

(a) The 2011 DP/NF Rate Reduction violates Section (a)(8) because it is going to effectively prevent many Medi-Cal beneficiaries from obtaining needed skilled nursing care with reasonable promptness. In many areas of the State Medi-Cal beneficiaries already have to be placed on waiting lists in order to access skilled nursing care. Due to the unprecedented magnitude of the 2011 DP/NF Rate Reduction, Plaintiffs are informed and believe and thereon alleged that many existing DP/NF providers are going to be forced out of business altogether or to severely restrict their services, or reduce the availability of services to Medi-Cal patients. As a result, Medi-Cal beneficiaries will not obtain skilled nursing services with reasonable promptness. In many areas of the State, there simply will be no available capacity at all in DP/NFs or freestanding SNFs. In other areas, there will be no available capacity among Medi-Cal providers of skilled nursing services to accept and care for Medi-Cal patients requiring skilled nursing care who have higher acuity and more complex conditions.

(b) The 2011 DP/NF Rate Reduction violates Section (a)(19) in that it will effectively dictate that skilled nursing care is being covered and reimbursed under Medi-Cal in a manner that is not in the best interests of patients for several reasons.

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(i) First, DP/NFs often furnish a higher level of care than freestanding SNFS, and often are the only source of higher level skilled nursing care in their communities. DP/NFs will be forced to close and/or restrict Medi-Cal services in response to the 2011 DP/NF Rate Reduction, thereby forcing patients to be placed in freestanding SNFs that may not provide the higher level of care that the more complex skilled nursing patients require. It is not in the best interests of higher acuity skilled nursing Medi-Cal patients to be placed in a facility that cannot provide the level of care that they potentially require.

(ii) Second, the closure of, or reduction in services by, DP/NFs will required patients to be placed in facilities that are very distant from the patients and their families' residences. It is not in the best interests of skilled nursing patients to have to travel long distances to get to a facility that can treat them and that will limit the ability of their loved ones to visit and support them.

(c) The 2011 DP/NF Rate Reduction violates Section 30(A) because:

(i) The Legislature gave DHCS the authority to reduce DP/NF payment rates, and DHCS exercised that authority, for purely budgetary reasons in order to achieve monetary savings for the State;

(ii) Neither the Legislature nor DHCS appropriately considered the factors of efficiency, economy, quality of care and access to services prior to authorizing and/or adopting the 2011 DP/NF Rate Reduction and seeking approval of such from CMS. Despite findings in multiple "studies" performed by DHCS that the rates paid under Medi-Cal to DP/NFs are adequate to ensure continued access to skilled nursing services for Medi-Cal beneficiaries, the Legislature and DHCS have not complied with the procedural requirements of Section 30(A). In particular, the Legislature gave DHCS the authority to implement the 2011 DP/NF Rate Reduction before a study was completed concerning the impact of that specific cut on the availability of skilled nursing services. Plaintiffs

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are informed and believe and thereon alleged that the fact there would be a new reduction in reimbursement for DP/NFs was a foregone conclusion before any purported study regarding that particular payment reduction was completed;

(iii) To the extent DHCS sought to amend the State Plan to implement the 2011 DP/NF Rate Reduction after purported studies of that particular reduction were completed, those studies cannot be considered adequate for the purposes of the requirements of Section 30(A). First, Plaintiffs are informed and believe and thereon alleged that the Department did not conduct any study of the relationship between provider costs and Medi-Cal payment rates after imposition of the 2011 DP/NF Rate Reduction. Rather, the only studies the State appears to have performed concerned beneficiary access to skilled nursing services. Second, with respect to the Department's conclusions about the impact of the proposed rate reduction on Medi-Cal beneficiary access to skilled nursing services, the Department's studies rely on factually unsupportable assumptions and comparisons and also contain numerous substantive and methodological flaws. Third, the Department's conclusions about continued beneficiary access to skilled nursing services are largely based on historical data concerning provider participation in Medi-Cal under previous payment rates. It is unreasonable to conclude that, because provider participation remained at a certain level under higher payment rates, participation will continue at that level once payment rates are significantly reduced. Finally, the Department's studies do not address all of the requirements of Section 30(A) in that they focus on beneficiary access to services only and do not assess the impact of the rate reduction on quality of care and efficiency;

(iv) The rates resulting from the 2011 DP/NF Rate Reduction are not reasonably related to provider costs and therefore are not consistent with quality of care or sufficient to ensure equal access to services. The State's own studies show that, after application of a much smaller, 5% rate reduction, California hospitals would, on average, be reimbursed at less than 80% of the costs they incur

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in providing DP/NF services to Medi-Cal beneficiaries. Accordingly, using the Department's own data, a reduction in rates by more than 20% is going significantly widen the gap between payment rates and costs. Indeed, CHA is informed and believes and on that basis alleges, that Medi-Cal DP/NF payments, as impacted by the 2011 DP/NF Rate Reduction, will on average reimburse about 60 to 65% of DP/NF costs. This discrepancy between Medi-Cal payment rates for DP/NF services and hospital costs is not "reasonable" for the purposes of the requirements of Section 30(A);

(v) The rates resulting from the 2011 DP/NF Rate Reduction are so far below the costs incurred by hospitals in providing DP/NF services to Medi-Cal beneficiaries that the rates are not consistent with quality of care. The reduced rates are lower than the costs efficiently incurred by DP/NFs in providing care to Medi-Cal beneficiaries and therefore are not consistent with quality of care. The reduced rates will result in Medi-Cal patients not having access to the level of care available in a DP/NF, but not available in freestanding SNFs in various areas of the State, and this is not consistent with quality of care. The reduced rates in certain areas of the State will result in patients having to travel to distant locations, away from their homes and families, to obtain skilled nursing services as DP/NFs in their area will close or limit services, which is not consistent with quality of care;

(vi) The rates resulting from the 2011 DP/NF Rate Reduction are sufficiently below the costs that hospitals incur in providing skilled nursing services to Medi-Cal beneficiaries that the rates are not sufficient to ensure that Medi-Cal beneficiaries have access to services to the same extent as the general population. As DP/NFs close or reduce the availability of services to Medi-Cal patients, there will no longer be adequate access for Medi-Cal patients to an appropriate level of skilled nursing care.

61. Violation of State Law: The 2011 DP/NF Rate Reduction is invalid and may not lawfully be implemented because it is in violation of State law in that

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the Director acted arbitrarily and capriciously in determining that the Medi-Cal payment rates resulting from the 2011 DP/NF Rate Reduction would be consistent with the requirements of Section 30(A). Under Section 14105.192, the Director is only authorized to implement, among other rate reductions, the 2011 DP/NF Rate Reduction based on a determination, "that that the payments that result from the application of this section will comply with applicable federal Medicaid requirements and that federal financial participation will be available." Welf. & Inst. Code § 14105.192(m). Under California law, administrative agencies are prohibited from acting in manner that is arbitrary, capricious, inconsistent with applicable law or lacking in evidentiary support. Further, agency decisions must be based on a consideration of all relevant factors and must demonstrate a rational connection between those factors and the choice made. Here, the Director's decision that the rates that will result from the 2011 DP/NF Rate Reduction will comply with the requirements of the federal Medicaid Act is arbitrary, capricious and lacking in evidentiary support because, among other reasons: (1) the Director effectively ignored evidence showing that DP/NFs services are not interchangeable with freestanding SNF services and evidence showing that DP/NFs have been closing at a steady rate recently in concluding that beneficiary access to skilled nursing care would not be impacted by the rate reduction; (2) the Director failed to adequately consider the factors of quality of care and efficiency in evaluating whether the 2011 DP/NF Rate Reduction meets Medicaid Act standards; and (3) the Director failed to account for governing law establishing that, under Section 30(A), provider payment rates must bear a reasonable relationship to the costs efficiently and economically operated providers incur in treating Medicaid beneficiaries.

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THE SECRETARY'S APPROVAL OF THE 2011 DP/NF RATE REDUCTION

62. Consistent with the foregoing, the Secretary's approval of the 2011 DP/NF Reduction, as set forth in SPAs 11-010, is invalid because it is arbitrary, capricious, an abuse of discretion and inconsistent with governing law for the following reasons:

(a) Because California is within the jurisdiction of the Ninth Circuit Court of Appeals, the Secretary is bound to apply the Ninth Circuit's interpretation of the Medicaid Act, including Section 30(A), when evaluating California SPAs for compliance with the Medicaid Act. The Ninth Circuit has held that Section 30(A) requires that Medicaid payment rates must be based on credible cost studies and must bear a reasonable relationship to provider costs in order to be consistent with quality of care and sufficient to ensure that beneficiaries have equal access to services. CHA is informed and believes, and on that basis alleges, that the Secretary has not applied the Ninth Circuit's interpretation of Section 30(A) in reviewing and approving the relevant SPA, but purported to consider only whether the rates may actually cause a reduction in beneficiary access to services. The Secretary has thus failed to follow and apply the applicable law.

(b) The question of whether Medi-Cal payment rates for DP/NFs are reasonably related to hospital costs is a relevant factor in the determination of whether the rates comply with Section 30(A). Plaintiff is informed and believes, and based thereon alleges, that the Secretary did not consider whether the Medi-Cal payment rates for DP/NFs after the implementation of the 2011 DP/NF Rate Reduction would bear a reasonable relationship to hospital costs in deciding to approve the relevant SPA.

(c) Plaintiff is informed and believes and thereon alleges that payment rates resulting from the 2011 DP/NF Rate Reduction would generally reimburse DP/NFs between roughly 60-65% of their costs. Accordingly, the

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Secretary could not have reasonably concluded that the rates resulting from the 2011 DP/NF Rate Reduction bear a reasonable relationship to costs. It was therefore arbitrary, capricious and an abuse of discretion for the Secretary to approve the relevant SPA.

(d) Plaintiffs are informed and believe and thereon allege that the Secretary did not consider other relevant factors in evaluating California's SPA related to the 2011 DP/NF Rate Reduction in that the Secretary did not adequately consider, among other things, the impact of the rate reduction on the quality of nursing care, whether the payment reductions would impact the promptness with which Medicaid beneficiaries are able to obtain DP/NF services and whether the reduction would impact the efficiency with which Medi-Cal services are delivered, perhaps through effectively eliminating certain DP/NF providers and thereby forcing Medi-Cal beneficiaries to either obtain care in freestanding skilled nursing facilities, which are not ideally suited to the level of care they need, or in acute care areas of hospitals, which provided more expensive care than DP/NFs.

(e) The record before the Secretary at the time she approved the SPA at issue demonstrates that the 2011 DP/NF Rate Reduction will adversely impact quality of care, and would not be sufficient to ensure that Medi-Cal beneficiaries would have equal access to services, because, among other things, the 2011 DP/NF Rate Reduction, which is effectively three reimbursement reductions rolled into one, will cause a significant deterioration in the financial health of many hospitals that will cause hospitals, among other things, to cut back, reduce and eliminate DP/NF services. The record before the Secretary demonstrates that hospitals that will be forced to take these types of actions include rural hospitals and critical access hospitals which are in many instances the only source of skilled nursing services for a large geographic region of the State. As a result, both Medi-Cal beneficiaries and other California residents will be faced with a situation in which needed health care services are not available, either at all, or within a

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reasonable time or distance. Further, with respect to quality of care, the evidence before the Secretary showed that, as DP/NFs close or reduce the availability of services to Medi-Cal patients, there will no longer be adequate access for Medi-Cal patients to an appropriate level of skilled nursing care.

(f) The Secretary's review and approval of SPA 11-010 also is arbitrary and capricious because it occurred in manner that was inconsistent with the Secretary's own public statements concerning the need for "transparency" in the SPA approval process. Interested parties, including CHA, were not afforded meaningful access to the information that was being exchanged between CMS and DHCS concerning the SPA. Rather, the only reason any of this information was provided at all was because CHA exercised its rights to public information under FOIA and California's PRA. Even then, DHCS refused to make the information available until after CMS made its decision to approve or disapprove the SPA, and CMS did not make information available to very shortly before it made its approval decision. Further, CMS refused to delay its approval decision to allow CHA to review and consider all of the information DHCS submitted in support of SPA 11-010. By reaching a decision on SPA 11-010 without affording interested parties an adequate opportunity to review the information DHCS submitted in response to CMS' RAI, the Secretary effectively rendered meaningless any public participation it had allowed in the process before that.

CHA'S STANDING AS AN ASSOCIATION

63. Many of CHA's members are Medi-Cal providers of DP/NF services. These Medi-Cal providers will suffer a concrete economic injury in the form of reduced payments for services by the unlawful implementation of the 2011 DP/NF Rate Reduction.

64. Moreover, Medi-Cal providers are in a unique position to advance the interests of Medi-Cal beneficiaries. The members of CHA, which provide services

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to Medi-Cal beneficiaries, have an extremely close relationship with their Medi-Cal beneficiary patients who seek that care. A Medi-Cal beneficiary cannot secure medical services without his/her health care providers, and without reimbursement by Medi-Cal for those services.

65. Medi-Cal providers are better positioned and informed as to the impact of a reimbursement rate cut on the services they intend to provide. Medi-Cal beneficiaries lack information about the effect of Medi-Cal reimbursement rates on providers in light of providers' costs and the further effect of a rate cut on the provision of services to Medi-Cal beneficiaries. Providers know the relationship of reimbursement to service and to their costs. As compared to beneficiaries, providers are in a better position to evaluate the State's decisional process and the data relied upon by the State in determining reimbursement rates. This informational hurdle is sufficient to confer standing on providers, who comprise substantial portions of Petitioner's membership, to assert the interests of their patients who are Medi-Cal beneficiaries.

66. Furthermore, Medi-Cal beneficiaries face economic hindrances to their ability to assert their own rights in this case. To qualify for Medi-Cal, an individual must demonstrate financial need for medical assistance from the State. In light of their finances and the cost of litigation, Medi-Cal beneficiaries may not be able to effectively protect their interests.

67. Consistent with the foregoing, CHA has a right and an enforceable interest to maintain this action against the Director under the Takings and Supremacy Clauses of the United States Constitution, the Takings Clause of the California Constitution, the Civil Rights Act, 42 U.S.C. § 1983 and the APA to enjoin the Director's continuing violation of the federal Medicaid law and to compel the Director to comply with the provisions of the applicable federal Medicaid law, as well as to challenge the Secretary's decision to approve the Director's implementation of the unlawful rate reduction.

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68. Moreover, Consistent with the foregoing, CHA, as an association representing the interests of California hospitals that participate in the Medi-Cal program and the Medi-Cal beneficiaries they treat, and as party seeking to compel the Director and Secretary to comply with their public duties as defined by federal law and state law, may maintain this action to: (1) enjoin Defendants' continuing violation of federal law and State law, as applicable; and (2) compel Defendant to comply with the provisions of the applicable law.

69. Under 28 U.S.C. § 2201, CHA is entitled to a declaration of its rights, its members' rights, and/or its members' patients' rights under federal Medicaid law.

FIRST CAUSE OF ACTION

(VIOLATION OF TAKINGS CLAUSE / SUPREMACY CLAUSE 42 U.S.C. § 1983)

(Against Defendant Director)

70. Plaintiff hereby incorporates by reference paragraphs 1 through 69, inclusive, as though fully set forth herein.

71. California law places restrictions on the ability of participating skilled nursing facilities, including DP/NFs, to both withdraw from Medi-Cal and cease operations. *See, e.g.* Cal. Health & Safety Code § 1336.2 and Cal. Welf. & Inst. Code § 14022.4. Such facilities are not permitted to immediately stop treating patients, but rather must take extensive steps to ensure that their patients are transferred to other patient facilities. However, in some instances, this class of facilities may be required, by statute, to continue treating particular patients who refuse transfer to other facilities. Along these lines, skilled nursing facilities, including DP/NFs, may only effectively withdraw from the Medi-Cal program when all Medi-Cal patients have left the care of the facility. California law therefore compels skilled nursing facilities, including DP/NFs, to furnish services to Medi-Cal beneficiaries, which constitutes an appropriation of these facilities and taking of

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their property by the State of California. Due to the outrageously low rates at which the Medi-Cal program will compensate DP/NFs after the 2011 DP/NF Rate Reduction goes into effect, Plaintiff CHA's members that operate DP/NFs will not be justly compensated by the State for their property in violation of the Fifth and Fourteenth Amendments of the United States Constitution.

72. The 2011 DP/NF Rate Reduction has been enacted by the California Legislature, and implemented by the Department, under color of State law. CHA represents the interests of hospitals that have been improperly deprived of their privately enforceable right to be free of government imposed takings of private property without just compensation that is guaranteed under the United States Constitution. Accordingly, the Director has violated 42 U.S.C. § 1983 with respect to the enactment and implementation of the 2011 DP/NF Rate Reduction.

73. Also, the 2011 DP/NF Rate Reduction is preempted by the Supremacy Clause of the United States Constitution, art. IV because the Director cannot simultaneously comply with the provisions of California law requiring the implementation of the rate reduction and the Constitutional prohibition on taking private property without adequate compensation.

SECOND CAUSE OF ACTION

(VIOLATION OF 42 U.S.C. § 1396a(a)(8)(A)/ SUPREMACY CLAUSE/42 U.S.C. § 1983)

(Against Defendant Director)

74. Plaintiff hereby incorporates by reference paragraphs 1 through 69, inclusive, as though fully set forth herein.

75. The 2011 DP/NF Rate Reduction is invalid and may not lawfully be implemented because it violates the terms of 42 U.S.C. § 1396a(a)(8) in that the rate reduction is going to effectively prevent many Medi-Cal beneficiaries from obtaining needed skilled nursing care with reasonable promptness. In many areas of

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the State Medi-Cal beneficiaries already have to be placed on waiting lists in order to access skilled nursing care. Due to the unprecedented magnitude of the 2011 DP/NF Rate Reduction, Plaintiffs are informed and believe and thereon alleged that many existing DP/NF providers are going to be forced out of business altogether or to severely restrict their services, or reduce the availability of services to Medi-Cal patients. As a result, Medi-Cal beneficiaries will not obtain skilled nursing services with reasonable promptness. In many areas of the State, there simply will be no available capacity at all in DP/NFs or freestanding SNFs. In other areas, there will be no available capacity among Medi-Cal providers of skilled nursing services to accept and care for Medi-Cal patients requiring skilled nursing care who have higher acuity and more complex conditions.

76. The 2011 DP/NF Rate Reduction has been enacted by the California Legislature, and implemented by the Department, under color of State law. 42 U.S.C. § 1983 creates an express cause of action when a state deprives a person of a right secured by federal law. 42 U.S.C. § 1396a(a)(8) secures a right in Medicaid beneficiaries to obtain Medicaid covered services with reasonable promptness. This right is enforceable under 42 U.S.C. § 1983 by Plaintiffs, both the individual beneficiary Plaintiffs and Plaintiff CHA, to the extent it represents the interests of its members' patients.

77. Also, the 2011 DP/NF Rate Reduction is preempted by the Supremacy Clause of the United States Constitution, art. IV because the Director cannot simultaneously comply with the provisions of California law requiring the implementation of the rate reduction and the requirements of 42 U.S.C. § 1396a(a)(8).

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THIRD CAUSE OF ACTION

(VIOLATION OF 42 U.S.C. § 1396a(a)(19) /SUPREMACY CLAUSE/42 U.S.C. § 1983)

(Against Defendant Director)

78. Plaintiff hereby incorporates by reference paragraphs 1 through 69, inclusive, as though fully set forth herein.

79. The 2011 DP/NF Rate Reduction is invalid and may not lawfully be implemented because it violates 42 U.S.C. § 1396a(a)(19) in that the reduction will effectively dictate that skilled nursing care is being covered and reimbursed, under Medi-Cal, in a manner that is not in the best interests of patients for several reasons. First, DP/NFs often furnish a higher level of care than freestanding SNFS, and are often the only source of higher level skilled nursing care in their communities. DP/NFs will be forced close and/or restrict Medi-Cal services in response to the 2011 DP/NF Rate Reduction, thereby forcing patients to be placed in freestanding SNFs that may not provide the higher level of care that the more complex skilled nursing patients require. It is not in the best interests of higher acuity skilled nursing Medi-Cal patients to be placed in a facility that cannot provide the level of care that they potentially require. Second, the closure of, or reduction in services by, DP/NFs will require patients to be placed in facilities that are very distant from the patients and their families' residences. It is not in the best interest of skilled nursing patients to have to travel long distances to get to a facility that can treat them and that will limit the ability of their loved ones to visit and support them.

80. The 2011 DP/NF Rate Reduction has been enacted by the California Legislature, and implemented by the Department, under color of State law. 42 U.S.C. § 1983 creates an express cause of action when a state deprives a person of a right secured by federal law. 42 U.S.C. § 1396a(a)(19) secures a right in Medicaid beneficiaries to have Medicaid policies in a manner that is consistent with their best interests. This right is enforceable under 42 U.S.C. § 1983 upon Plaintiffs, both the

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individual beneficiary Plaintiffs and Plaintiff CHA, to the extent it represents the interests of its members' patients.

81. Also, the 2011 DP/NF Rate Reduction is preempted by the Supremacy Clause of the United States Constitution, art. IV because the Director cannot simultaneously comply with the provisions of California law requiring the implementation of the rate reduction and the requirements of 42 U.S.C. § 1396a(a)(19).

FOURTH CAUSE OF ACTION

(VIOLATION OF 42 U.S.C. § 1396a(a)(30)(A)/SUPREMACY CLAUSE)

(Against Defendant Director)

82. Plaintiff hereby incorporates by reference paragraphs 1 through 69, inclusive, as though fully set forth herein.

83. The 2011 DP/NF Rate Reduction violates Section 30(A) of the Medicaid Act because:

(a) The Legislature gave DHCS the authority to reduce DP/NF payment rates, and DHCS exercised that authority, for purely budgetary reasons in order to achieve monetary savings for the State;

(b) Neither the Legislature nor DHCS appropriately considered the factors of efficiency, economy, quality of care and access to services prior to authorizing and/or adopting the 2011 DP/NF Rate Reduction and seeking approval of such from CMS. Despite findings in multiple "studies" performed by DHCS that the rates paid under Medi-Cal to DP/NFs are adequate to ensure continued access to skilled nursing services for Medi-Cal beneficiaries, the Legislature and DHCS have not complied with the procedural requirements of Section 30(A). In particular, the Legislature gave DHCS the authority to implement the 2011 DP/NF Rate Reduction before a study was completed concerning the impact of that specific cut on the availability of skilled nursing services. Plaintiffs are informed and believe and

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thereon alleged that the fact there would be a new reduction in reimbursement for DP/NFs was a foregone conclusion before any purported study regarding that particular payment reduction was completed;

(c) To the extent DHCS sought to amend the State Plan to implement the 2011 DP/NF Rate Reduction after purported studies of that particular reduction were completed, those studies cannot be considered adequate for the purposes of the requirements of Section 30(A). First, Plaintiffs are informed and believe and thereon allege that the Department did not conduct any study of the relationship between provider costs and Medi-Cal payment rates after imposition of the 2011 DP/NF Rate Reduction. Rather, the only studies the State appears to have performed concerned beneficiary access to skilled nursing services. Second, with respect to the Department's conclusions about the impact of the proposed rate reduction on Medi-Cal beneficiary access to skilled nursing services, the Department's studies rely on factually unsupportable assumptions and comparisons and also contain numerous substantive and methodological flaws. Third, the Department's conclusions about continued beneficiary access to skilled nursing services are largely based on historical data concerning provider participation in Medi-Cal under previous payment rates. It is unreasonable to conclude that, because provider participation remained at a certain level under higher payment rates, participation will continue at that level once payment rates are significantly reduced. Finally, the Department's studies do not address all of the requirements of Section 30(A) in that they focus on beneficiary access to services only and do not assess the impact of the rate reduction on quality of care and efficiency;

(d) The rates resulting from the 2011 DP/NF Rate Reduction are not reasonably related to provider costs and therefore are not consistent with quality of care or sufficient to ensure equal access to services. The State's own studies show that, after application of a much smaller, 5% rate reduction, California hospitals would, on average, be reimbursed at less than 80% of the costs they incur in

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providing DP/NF services to Medi-Cal beneficiaries. Accordingly, using the Department's own data, a reduction in rates by more than 20% is going significantly widen the gap between payment rates and costs. Indeed, CHA is informed and believes and on that basis alleges, that Medi-Cal DP/NF payments, as impacted by the 2011 DP/NF Rate Reduction, will, on average, reimburse about 60 to 65 % of DP/NF costs. This discrepancy between Medi-Cal payment rates for DP/NF services and hospital costs is not "reasonable" for the purposes of the requirements of Section 30(A);

(e) The rates resulting from the 2011 DP/NF Rate Reductions are so far below the costs incurred by hospitals in providing DP/NF services to Medi-Cal beneficiaries that the rates are not consistent with quality of care. The reduced rates are lower than the costs efficiently incurred by DP/NFs in providing care to Medi-Cal beneficiaries and therefore are not consistent with quality of care. The reduced rates will result in Medi-Cal patients not having access to the level of care available in a DP/NF, but not available in freestanding SNFs in various areas of the State, and this is not consistent with quality of care. The reduced rates in certain areas of the State will result in patients having to travel to distant locations, away from their homes and families, to obtain skilled nursing services as DP/NFs in their area will close or limit services, which is not consistent with quality of care;

(f) The rates resulting from the 2011 DP/NF Rate Reduction are sufficiently below the costs that hospitals incur in providing skilled nursing services to Medi-Cal beneficiaries that the rates are not sufficient to ensure that Medi-Cal beneficiaries have access to hospital services to the same extent as the general population. As DP/NFs close or reduce the availability of services to Medi-Cal patients, there will no longer be adequate access for Medi-Cal patients to an appropriate level of skilled nursing care.

84. The 2011 DP/NF Rate Reduction is thus preempted by the Supremacy Clause of the United States Constitution, art. IV, because the reduced rates that will

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result from the Reduction, enacted solely for budgetary reasons in disregard of the requirements of Section 30(A), stand as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress in the enactment of said section. Moreover, the 2011 DP/NF Rate Reduction is preempted under the Supremacy Clause because the Director cannot simultaneously comply Section 30(A) and implement and apply the Reduction.

FIFTH CAUSE OF ACTION

(VIOLATION OF STATE LAW/WRIT OF MANDATE, CAL. CODE CIV. PROC. § 1085)

(Against Defendant Director)

85. Plaintiffs hereby incorporates by reference paragraphs 1 through 69, inclusive, as though fully set forth herein.

86. Plaintiff CHA, on behalf of its members, has a beneficial interest that rates established for DP/NF services comply with the requirements of the California Constitution, California statutes and California case law concerning the obligations and duties of administrative agencies.

87. The Director has a duty to comply with the California Constitution and other California laws, but has violated this duty, by adopting and implementing the 2011 DP/NF Rate Reduction in violation the express terms of Section 14015.192 and Section 19, of Article I of the California Constitution.

88. The 2011 DP/NF Rate Reduction violates Article I, Section 19 of the California Constitution, which prohibits the State from taking or damaging private property for a public use without paying just compensation. California law places restrictions on the ability of participating skilled nursing facilities, including DP/NFs, to both withdraw from Medi-Cal and cease operations. *See, e.g.* Cal. Health & Safety Code § 1336.2 and Cal. Welf. & Inst. Code § 14022.4. Such facilities are not permitted to immediately stop treating patients, but rather must take

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extensive steps to ensure that their patients are transferred to other patient facilities. However, in some instances, this class of facilities may be required, by statute, to continue treating particular patients who refuse transfer to other facilities. Along these lines, skilled nursing facilities, including DP/NFs, may only effectively withdraw from the Medi-Cal program when all Medi-Cal patients have left the care of the facility. California law therefore compels skilled nursing facilities, including DP/NFs, to furnish services to Medi-Cal beneficiaries, which constitutes an appropriation of these facilities and taking of their property by the State of California. Due to the outrageously low rates at which the Medi-Cal program will compensate DP/NFs after the 2011 DP/NF Rate Reduction goes into effect, Plaintiff CHA's members that operate DP/NFs will not be justly compensated by the State for their property in violation of Article I, Section 19 of the California Constitution.

89. The 2011 DP/NF Rate Reduction was implemented in a manner inconsistent with the terms of Section 14105.192. Under Section 14105.192, the Director is only authorized to implement, among other rate reductions, the 2011 DP/NF Rate Reduction based on a determination, "that that the payments that result from the application of this section will comply with applicable federal Medicaid requirements and that federal financial participation will be available." Welf. & Inst. Code § 14105.192(m). Under California law, administrative agencies are prohibited from acting in manner that is arbitrary, capricious, inconsistent with applicable law or lacking in evidentiary support. Further, agency decisions must be based on a consideration of all relevant factors and must demonstrate a rational connection between those factors and the choice made. Here, the Director's decision that the rates that will result from the 2011 DP/NF Rate Reduction will comply with the requirements of the federal Medicaid Act is arbitrary, capricious and lacking in evidentiary support because, among other reasons: (1) the Director effectively ignored evidence showing that DP/NFs services are not interchangeable with freestanding SNF services and evidence showing that DP/NFs have been closing at a

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steady rate recently in concluding that beneficiary access to skilled nursing care would not be impacted by the rate reduction; (2) the Director failed to adequately consider the factors of quality of care and efficiency in evaluating whether the 2011 DP/NF Rate Reduction meets Medicaid Act standards; and (3) the Director failed to account for governing law establishing that, under Section 30(A), provider payment rates must bear a reasonable relationship to the costs efficiently and economically operated providers incur in treating Medicaid beneficiaries.

90. Plaintiffs have performed all conditions precedent to the filing of the petition for mandamus. No other adequate remedy exists under statute, regulation or other provisions of law. Under California law, the existence of declaratory and injunctive relief does not prevent the use of mandate. *County of Los Angeles* v. *State Department of Public Health*, 158 Cal.App.2d 425, 446 (1958).

SIXTH CAUSE OF ACTION

(VIOLATION OF

ADMINISTRATIVE PROCEDURE ACT, 5 U.S.C. §§ 701-706)

(Against Defendant Secretary)

91. Plaintiff hereby incorporates by reference paragraphs 1 through 69, inclusive, as though fully set forth herein.

92. Under the federal Administrative Procedure Act ("APA"), 5 U.S.C. §§ 701-706, courts must overturn agency action that is arbitrary, capricious, an abuse of discretion or not otherwise in accordance with the law.

93. The Secretary's approval of the SPA setting for the 2011 DP/NF Rate Reduction is the act of an administrative agency and subject to review under the APA. The Secretary's approval of the SPA is invalid under the APA because it is arbitrary, capricious and an abuse of discretion, and otherwise inconsistent with governing law, for the following reasons:

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(a) Because California is within the jurisdiction of the Ninth Circuit Court of Appeals, the Secretary is bound to apply the Ninth Circuit's interpretation of the Medicaid Act, including Section 30(A), when evaluating California SPAs for compliance with the Medicaid Act. The Ninth Circuit has held that Section 30(A) requires that Medicaid payment rates must be based on credible cost studies and must bear a reasonable relationship to provider costs in order to be consistent with quality of care and sufficient to ensure that beneficiaries have equal access to services. CHA is informed and believes, and on that basis alleges, that the Secretary has not applied the Ninth Circuit's interpretation of Section 30(A) in reviewing and approving the relevant SPA, but purported to consider only whether the rates may actually cause a reduction in beneficiary access to services. The Secretary has thus failed to follow and apply the applicable law;

(b) The question of whether Medi-Cal payment rates for DP/NFs are reasonably related to hospital costs is a relevant factor in the determination of whether the rates comply with Section 30(A). Plaintiffs are informed and believes, and based thereon alleges, that the Secretary did not consider whether the Medi-Cal payment rates for DP/NFs after the implementation of the 2011 DP/NF Rate Reduction would bear a reasonable relationship to hospital costs in deciding to approve the relevant SPA;

(c) Plaintiffs are informed and believe and thereon allege that payment rates resulting from the 2011 DP/NF Rate Reduction will generally reimburse DP/NFs roughly 60- 65% of their costs. Accordingly, the Secretary could not have reasonably concluded that the rates resulting from the 2011 DP/NF Rate Reduction bear a reasonable relationship to costs. It was therefore arbitrary, capricious and an abuse of discretion for the Secretary to approve the relevant SPA;

(d) Plaintiffs are informed and believe and thereon allege that the Secretary did not consider other relevant factors in evaluating California's SPA related to the 2011 DP/NF Rate Reduction in that the Secretary did not adequately

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consider, among other things, the impact of the rate reductions on the quality of nursing care, whether the payment reduction would impact the promptness with which Medicaid beneficiaries are able to obtain skilled nursing services and whether the reduction would impact the efficiency with which Medi-Cal services are delivered, perhaps through effectively eliminating certain DP/NF providers and thereby forcing Medi-Cal beneficiaries to either obtain care in freestanding skilled nursing facilities, which are not ideally suited to the level of care they need, or in acute care areas of hospitals, which provided more expensive care than DP/NFs;

(e) The record before the Secretary at the time she approved the SPA at issue demonstrates that the DP/NF Rate Reduction will adversely impact quality of care, and would not be sufficient to ensure that Medi-Cal beneficiaries would have equal access to services, because, among other things, the 2011 DP/NF Rate Reduction, which is effectively three reimbursement reductions rolled into one, will cause a significant deterioration in the financial health of many hospitals that will cause hospitals, among other things, to cut back, reduce and eliminate DP/NF services. The record before the Secretary demonstrates that hospitals that will be forced to take these types of actions include rural hospitals and critical access hospitals which are in many instances the only source of skilled nursing services for a large geographic region of the State. As a result, both Medi-Cal beneficiaries and other California residents will be faced with a situation in which needed health care services are not available, either at all, or within a reasonable time or distance. Further, with respect to quality of care, the evidence before the Secretary showed that, as DP/NFs close or reduce the availability of services to Medi-Cal patients, there will no longer be adequate access for Medi-Cal patients to an appropriate level of skilled nursing care;

(f) The Secretary's review and approval of SPA 11-010 also is arbitrary and capricious because it occurred in manner that was inconsistent with the Secretary's own public statements concerning the need for "transparency" in the

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SPA approval process. Interested parties, including CHA, were not afforded meaningful access to the information that was being exchanged between CMS and DHCS concerning the SPA. Rather, the only reason any of this information was provided at all was because CHA exercised its rights to public information under FOIA and California's PRA. Even then, DHCS refused to make the information available until after CMS made its decision to approve or disapprove the SPA, and CMS did not make information available to very shortly before it made its approval decision. Further, CMS refused to delay its approval decision to allow CHA to review and consider all of the information DHCS submitted in support of SPA 11-010. By reaching a decision on SPA 11-010 without affording interested parties an adequate opportunity to review the information DHCS submitted in response to CMS' RAI, the Secretary effectively rendered meaningless any public participation she had allowed in the process before that.

SEVENTH CAUSE OF ACTION

(DECLARATORY RELIEF)

(Against All Defendants)

94. Plaintiffs hereby incorporates by reference paragraphs 1 through 69, inclusive, as though fully set forth herein.

95. An actual and justiciable controversy exists between Plaintiffs and Director regarding the validity of the 2011 DP/NF Rate Reduction. Plaintiffs, including Plaintiff CHA on behalf of its members and its members, Medi-Cal patients, contends that the reimbursement reduction is invalid and unlawful in violation of the United States Constitution, the California Constitution, federal statute and State laws, while the Director contends that the reimbursement limitations are valid in all respects.

96. An actual and justiciable controversy exists between Plaintiffs and Defendant Secretary regarding whether the SPA setting forth the 2011 DP/NF Rate

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Reduction complied with the requirements of the federal Medicaid Act. Plaintiffs contend that the Secretary's approval of the relevant SPA was arbitrary, capricious, an abuse of discretion and not in accordance with applicable law, while the Secretary contends that she properly approved the SPA as in compliance with the Medicaid Act and APA.

97. Accordingly, pursuant to 28 U.S.C. § 2201, Plaintiffs request this Court to declare that the 2011 DP/NF Rate Reduction is invalid, unlawful and preempted by federal law.

98. No administrative appeal process or other administrative remedy is available to Plaintiffs and/or Plaintiff's members, as applicable, to challenge the 2011 DP/NF Rate Reduction.

99. All of the said injuries are great, immediate, and irreparable, for which damages at law are inadequate, and for which Plaintiffs, and/or its members, have no plain, adequate or speedy relief at law or otherwise.

WHEREFORE, Plaintiffs pray for judgment as follows:

1. For an Order declaring that the 2011 DP/NF Rate Reduction violates the Takings Clause of the United States Constitution, the Takings Clause of the California Constitution, Section (a)(8), Section (a)(19), Section 30(A), the APA, California law and is thus invalid and/or preempted by the Supremacy Clause of the United States Constitution, art. IV;

2. For an Order declaring that it was arbitrary, capricious, an abuse of discretion and not in accordance with applicable law for the Secretary to approve the SPA purporting to incorporate the 2011 DP/NF Rate Reduction into California's State Plan.

3. For an Order setting aside the Secretary's approval of the SPA purporting to incorporate the 2011 DP/NF Rate Reduction into California's State Plan.

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4. For an Order preliminarily and permanently enjoining the Director from effectuating the 2011 DP/NF Rate Reduction;

5. For the costs of suit, including reasonable attorneys' fees incurred by Plaintiffs, as permitted under 42 U.S.C. § 1988 or otherwise, and

6. Such other and further relief as may be just and proper.

DATED: November 1, 2011

HOOPER, LUNDY & BOOKMAN, INC.

By: _____
JORDAN B. KEVILLE
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Managed Pharmacy Care; Independent Living Center of Southern California, Inc; California Foundation for Independent Living Centers; Mark Beckwith; Gerald Shapiro, Pharm.D., dba Uptown Pharmacy & Gift Shoppe; Sharon Stern, dba Central Pharmacy; Tran Pharmacy, Inc., dba Tran Pharmacy; Odette Leonelli, Pharm.D., dba Kovacs-Frey Pharmacy; and Armen Tatevossian

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA, WESTERN DIVISION

Civil No. CV11-9211 (PJWx)

COMPLAINT

MANAGED PHARMACY CARE, a California corporation; INDEPENDENT LIVING CENTER OF SOUTHERN CALIFORNIA, INC., a California corporation; CALIFORNIA FOUNDATION FOR INDEPENDENT LIVING CENTERS, a California corporation; GERALD SHAPIRO, Pharm.D., doing business as Uptown Pharmacy & Gift Shoppe; SHARON STERN, doing business as Central Pharmacy; TRAN PHARMACY, INC., a California corporation, doing business as Tran Pharmacy; ODETTE LEONELLI, Pharm.D., doing business as Kovacs-Frey Pharmacy; MARKET PHARMACY, INC., doing business as Market Pharmacy; and MARK BECKWITH

Plaintiffs,

-vs.-

KATHLEEN SEBELIUS, Secretary of the U.S. Department of Health and Human Services; TOBY DOUGLAS, Director of Department of Health Care Services of State of California; and DOES 1 through 10

Defendants.

Plaintiffs complain of the defendants KATHLEEN SEBELIUS, Secretary ("Secretary") of the U.S. Department of Health and Human Services ("HHS"), and TOBY DOUGLAS, Director ("Director") of the Department of Health Care Services ("DHCS") of the State of California; and DOES 1 through 50, and for claims for relief allege:

JURISDICTION AND VENUE

1. The Court has jurisdiction under 28 U.S.C. §§ 1331 1391, 42 U.S.C. § 1983; the 14th Amendment Due Process Clause and Privileges and Immunities Clause; and the Administrative Procedure Act, 4 U.S.C. § 701 et seq. *Association of Data Processing Organizations, Inc. v. Camp*, 397 U.S. 150 (1970).

2. The actions of the Defendants complained of were and will be done in all parts of California, including the County of Los Angeles, and injure and cause, and will injure, and will cause an adverse effect upon the health, economic, and other interests of:

- Plaintiffs Mark Beckwith and Margaret Dowling;
- the pharmacy Plaintiffs; and the pharmacy members of the Plaintiff, Managed Pharmacy Care ("MPC"); and,
- the patients and clients of the pharmacy Plaintiffs; MPC; the Independent Living Center of Southern California, Inc. ("ILC"); and the California Foundation for Independent Living Centers ("CFILC").

The Defendants and the California Attorney General each has an office in the County of Los Angeles.

RELATED CASES

3. The following cases in the within Court:

	Court	Case No.
Independent Living Center of Southern California, Inc. v Douglas	D.C.Cal.,C.D.	2:08-cv-03315 CAS-MAN
Independent Living Center of Southern California, Inc. v Douglas	"	2:09-cv-0382 CAS-MAN
California Pharmacists Assn. v. Douglas	"	2:09-cv-0722 CAS-MAN
California Hospital Assn. v. Douglas	"	2:11-cv-09078 JHN-MRW
Douglas v. Independent Living Center of Southern California, Inc. (submission order vacated; further briefing ordered on November 4, 2011 on the issues raised by the same CMS rulings sued upon in the with MPC case, and the above *California Hospital* case, 2:11-cv-09078 JHN-MRW).	U.S. Supreme Court	Nos. 09-958 and 09-1158

are related to the within case, in that the primary facts, issues, evidence, and claims of the parties, and many of the parties, in these prior cases and the within case are identical. It would waste of judicial resources not to assign this new case to the same judge, namely, the Hon. Christina A. Snyder.

INTRODUCTION

4. DHCS is the single State agency which administers the federal-state funded health services program in California under the Medicaid Act, Title XIX, Social Security Act, ("S.S. Act"), § 1900 et seq.

5. This program is called "Medi-Cal." All references to "Medi-Cal" are to this Title XIX program in California.

6. Plaintiffs, pursuant to the Administrative Procedure Act, 5 U.S.C. § 701, et seq., challenge, and request judicial review of, and injunctive and declaratory relief to vacate and set aside the action of the Secretary of HHS, by and through Centers for Medicare and Medicaid

Services ("CMS"), an agency and agent of HHS: to wit, the October 27, 2011 action of CMS under the Medicaid Act, S.S Act, § 1902(a)(5) to approve a State Plan Amendment ("SPA") requested by the Director, which SPA, in its substance provides that payments by DHCS for services furnished on or after June 1, 2011, to Medi-Cal beneficiaries in the Medi-Cal fee-for-service program, – including pharmacy services including prescribed drugs, – shall be reduced by ten percent (10%); and that the Director may recoup the 10% amounts previously paid to Medi-Cal providers retroactive to June 1, 2011, (even though such services to and for the benefit of the State of California, performed at the special instance and request of the State, had a reasonable value equal to or more than the amount paid by the Medi-Cal program to each provider for that provider's services).

7. Each of the Plaintiffs, and the thousands of Medi-Cal beneficiaries who are the patients and clients of the Plaintiffs, are and will suffer legal wrong because of the agency action complained, and, also, have health, economic, professional and other cognizable interests which are and will be adversely affected and aggrieved, by the agency action complained of.

PARTIES

8. (a) The plaintiff **MPC** is a California corporation, which is resident in and whose principal place of business is in Lake Arrowhead, California.

9. (a) The plaintiff **ILC** is a nonprofit California corporation which was duly organized and incorporated in California on July 25, 1977 pursuant to the General Nonprofit Corporation Law of the State of California.

(b) ILC has its principal office and place of business in, and does business in the County of Los Angeles, California.

10. (a) The plaintiff **GERALD SHAPIRO**, Pharm.D., is a duly licensed registered pharmacist with License No. 24377, who owns and operates a duly licensed retail pharmacy

under the fictitious name of Uptown Pharmacy & Gift Shoppe, under retail pharmacy license No. PHY 41615, in the City of Los Angeles, California.

(b) The plaintiff SHAPIRO's pharmacy participates in the Medi-Cal fee-for-service program and also in the Medi-Cal managed care program, under Medi-Cal provider identification No. PHA 416150.

11. (a) The plaintiff SHARON STEEN is an individual who is a co-owner and operates a licensed retail pharmacy, under the fictitious name Central Pharmacy, under retail pharmacy license No. PHY 38051, in the City of Santa Monica, California.

(b) The plaintiff STEEN's pharmacy participates in the Medi-Cal fee-for-service program and also in the Medi-Cal managed care program, under Medi-Cal provider identification No. PHA 380510.

12. (a) The Plaintiff TRAN PHARMACY, INC. is a California corporation which owns and operates a duly licensed retail pharmacy under the fictitious name of Tran Pharmacy, under retail pharmacy license No. PHY 43647, in Garden Grove, California.

(b) The Tran Pharmacy participates in the Medi-Cal fee-for-service program and also in the Medi-Cal managed care program, under Medi-Cal provider identification No. PHA 436470.

13. (a) The plaintiff ODETTE LEONELLI, Pharm.D., owns and operates a duly licensed retail pharmacy under the fictitious name Kovacs-Prey Pharmacy, under retail pharmacy license No. PHY 48888, in Redondo Beach, California.

(b) The Kovacs-Prey Pharmacy participates in the Medi-Cal fee-for-service program and also in the Medi-Cal managed care program, under Medi-Cal provider identification No. PHA 488880.

14. (a) The plaintiff MARKET PHARMACY, INC. is a California corporation which owns and operates a duly licensed retail pharmacy under the fictitious name Market Pharmacy, in Northridge, California.

(b) The Market Pharmacy participates in the Medi-Cal fee-for-service program and also in the Medi-Cal managed care program

15. The plaintiff MARK BECKWITH is a quadriplegic Medi-Cal beneficiary who is a resident and citizen of Berkeley, California.

16. (a) The defendant DHCS is a department of the State of California. DHCS is the single State agency which, under S.S. Act, § 1902(a)(5), as well as under § 14000 et seq. California Welfare and Institutions ("Welf. & Inst.") Code, exclusively administers the Medi-Cal program.

(b) The defendant Director is the director of DHCS. The Director is exclusively empowered by §§ 14100.1 and 14105 Welf. & Inst. Code to set all policies, rules and regulations in the Medi-Cal program, including all rates payable to Medi-Cal providers. The Director has an office in the County of Los Angeles. The Director is sued in his official capacity, only.

(c) The defendant KATHLEEN SEBELIUS is the Secretary of HHS. She is sued in her official capacity, only.

17. Plaintiffs are each citizens and residents of the State of California, and in such capacity sue herein, also, cumulative to their other claims, on their own behalf, in their own interest, and in the interest of the Medi-Cal patients and clients of the Plaintiffs, and on behalf of the public, to procure the performance of public duty by each of the Defendants, as set forth hereinbelow.

18. Plaintiffs also sue in a prudential *jus tertii* capacity to assert their interests as well as the interests of the Medi-Cal patients and clients of the Plaintiffs, as the case may be.

19. Plaintiffs – and their Medi-Cal patients and clients on behalf of whom Plaintiffs sue herein, – also have standing and a claim for relief against the defendants inasmuch as each has suffered, will suffer, and is threatened to suffer, concrete and irreparable injury, defined at

the least as an adverse effect upon a health, economic, professional and other cognizable interest of the Plaintiffs, respectively, and of the patients and clients, respectively, of the Plaintiffs, unless the defendants are enjoined by the injunctions prayed for, or in the alternative, a judgment for declaratory relief is issued.

INTRODUCTION

20. Medi-Cal is a major component of the "safety net" that ensures the State's poor §have access to health care services.

STATUTE CHALLENGED

21. Assembly Bill ("AB") 97, enacted March 24, 2011 as part of Chap. 3, California Stats. 2011, amended Cal. Welf. & Inst. Code, § 14105.191 provides in substance that the Director shall adjust Medi-Cal provider payments, by reducing payments to pharmacies, by ten percent (10%) for Medi-Cal fee-for-service benefits, for dates of service on and after June 1, 2011; by reducing payments to managed health care plans in the Medi-Cal program by the actuarial equivalent amount of the Medi-Cal fee-for-service payment reduction; and, when federal approval is obtained, implement these payment reductions retroactively to June 1, 2011.

22. Specifically, Section 93.5 of AB 97 amended Cal. Welf. & Inst. Code, § 14105.192 to provide in relevant part:

> (c) Notwithstanding any other provision of law, the director shall adjust provider payments, as specified in this section.
>
> (d) (1) Except as otherwise provided in this section, payments shall be reduced by 10 percent for Medi-Cal fee-for-service benefits for dates of service on or after June 1, 2011.
>
> (2) For managed care health plans that contract with the department pursuant to this chapter or Chapter 8 (commencing with Section 14200), except contracts with Senior Care Action Network and AIDS Healthcare Foundation, payments shall be reduced by the actuarial equivalent amount of the payment reduction specified in this section pursuant to contract amendments or change orders effective on July 1, 2011, or thereafter.
>
> . . .
>
> (f) Subject to the exception for services listed in Subdivision (h), the payment reductions

required by subdivision (d) shall apply to the benefits rendered by any provider who may be authorized to bill for the service, including, but not limited to, physicians, podiatrists, nurse practitioners, certified nurse-midwives, nurse anesthetists, and organized outpatient clinics.

(m) Notwithstanding any other provision of this section, the payment reductions and adjustments provided for in subdivision (d) shall be implemented only if the director determines that the payments that result from the application of this section will comply with applicable federal Medicaid requirements and that federal financial participation will be available.

(1) In determining whether federal financial participation is available, the director shall determine whether the payments comply with applicable federal requirements, including those set forth in Section 1396a(a)(30)(A) of Title 42 of the United States Code.

(2) To the extent the director determines that the payments do not comply with the federal Medicaid requirements or that federal financial participation is not available with respect to payment that is reduced pursuant to this section, the director retains the discretion to not implement the particular payment reduction or adjustment and may adjust the payment as necessary to comply with federal Medicaid requirements.

. . .

(n) The department shall seek any necessary federal approvals for the implementation of this section.

(o) This section shall not be implemented until federal approval is obtained. When federal approval is obtained, the payments resulting from the application of subdivision (d) shall be implemented retroactively to June 1, 2011, or on such other date or dates as may be applicable.

AB 97 further provides:

SEC. 106. This act addresses the fiscal emergency declared and reaffirmed by the Governor by proclamation on January 20, 2011, pursuant to subdivision (f) of Section 10 of Article IV of the California Constitution.

SEC. 107. This act is a bill providing for appropriations related to the Budget Bill within the meaning of Section 12 of Article IV of the California Constitution, has been identified as related to the Budget Bill, and shall take effect immediately.

SEC. 108. This act is an emergency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to make the necessary statutory changes to implement the Budget Act of 2011 at the earliest possible time, it is necessary that this act take effect immediately.

23. Note: Subd. (o) provisions of subd. (o) relating to Cal,. Welf. & Inst. Code of Cal. Welf. & Inst. Code, § 14105.192 was amended June 29, 2011 by Sec. 13 of Chap. 29, Cal. Stats. 201, without any change to the substance of the provisions of subd. (o) relating to Cal,. Welf. & Inst. Code, § 14105.192.[1]

24. Hereinafter, all references to "AB 97" shall include and mean:

"AB 97, as amended by AB 102,"

unless otherwise stated.

FACTS COMMON TO ALL CLAIMS

25. At all times in the history of the Medicaid Act, there has been a substantial conflict of interest on the part of the Secretary, whose ultimate client is the United States. The conflict of interest is, that if Secretary looks the other way when a State does not provide sufficient payment to Medicaid providers to enable them to furnish quality health services as required by the Medicaid rate-setting law, 42 U.S.C. § 1396a(a)(30)(A) – "Section 30A," – then the public fisc of both the State and the United States profit greatly,

26. This conflict of interest of the Secretary has been publicly conceded by past Secretaries of HHS, in their amicus brief filed in the related case, *Douglas v. Independent Living*

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[1] Subd. (o) was therein amended relating to Cal. Welf. & Inst. Code, § 14105.192, to read as follows:

> (o) (1) The payment reductions and adjustments set forth in this section shall not be implemented until federal approval is obtained.
>
> . . .
>
> (3) When federal approval is obtained, the payments resulting from the application of this section shall be implemented retroactively to June 1, 2011, or on any other date or dates as may be applicable.

Thus, this amendment only involved changing the words in the prior subd. (o) of "on such other date or dates" to "on any other date or dates.: : which in essence is no meaningful change at all.

Center of Southern California, No. 09-958, ("*Independent Living I*"); (further briefing ordered, November 4, 2011, due to the CMS rulings in the within case at bar, and in the related case in the within court, *California Hospital Assn. v. Douglas*, 2:09-cv-09078 JHN-MRW).

27. Whether because of this public conflict of interest or despite it, the Secretary has never in the entire history of the Social Security Act, ever sued or imposed any penalty upon any State's failure to establish the minimum Medicaid provider reimbursement rates as required by Section 30A, namely, the minimum requirements of:

- setting payment rates in the procedural manner required by Section 30A, (namely, by a reasonable process which includes, at the least, consideration of the Section 30A factors of efficiency, quality of services, and equal access to services (the same as available to the general population in the same area), and quality of services; and,

- setting payment rates high enough to satisfy the quality and equal access provisions of Section 30A.

28. Four times, at the least, in 1987, (10% cut under Cal. Welf. & Inst. Code§ 14105), 2003 (5% across the board cut); 2008 (10% cut of AB 5), and 2009 (5% cut of AB 1183); each of which was enjoined by private action of providers and beneficiaries adversely affected by these cuts: not, by the Secretary at all, who did not oppose these cuts and argued at least once, (in 1987), they did not violate the Medicaid Act.

FIRST CLAIM FOR RELIEF

29. Now, still once again, the California legislature did, on March 24, 2011, enact AB 97 to reduce Medi-Cal provider rates across the board, including pharmacy rates, in the Medi-Cal fee-for-service system; and, to enact an actuarial equivalent payment reduction to all Medi-Cal managed care plans (who will inevitably, as surely as night follows day, pass this equivalent payment reduction to all *their* providers of services, including pharmacy services). (AB 97, as amended by AB 102, *supra*.) (Hereinafter, collectively, the "10% payment reduction.")

30. And once again, each of the California legislature, and the Director, acted in excess of and without jurisdiction, in conflict with and contrary to Section 30A, to enact AB 97, and the 10% payment reduction of AB 97, in violation, even deliberate violation, of Section 30A; with the violations consisting of this:

- the legislature enacted AB 97, and the 10% payment reduction of AB 97, purely for budgetary reasons, in which budgetary considerations were the conclusive if not the exclusive consideration in enacting the reduction; and, the Director likewise approved the 10% payment reduction, purely for budgetary reasons, in which budgetary considerations were the conclusive if not the exclusive consideration of the Director in approving and implementing the decision of the legislature to enact AB 97. Therein and thereby, the California legislature and the Director, respectively and successive, acted in excess of and without jurisdiction whatsoever or at all, in enacting and in implementing B 97 and the 10% payment reduction of AB 97, in respect to all Medi-Cal services including pharmacy services; including not only withholding 10% from all payments to Medi-Cal providers including pharmacies, in the Medi-Cal fee-for-service program; and also withholding 10% payments to Medi-Cal managed care plans who will in turn pass through this reduction to all providers, including pharmacies, in the Medi-Cal managed care program.

31. Also, the Director will unless restrained, recoup by self help and offsetting, all the 10% amounts paid by DHCS to Medi-Cal providers including the Plaintiffs, since June 1, 2011; ruining them, and preventing them from further serving their Medi-Cal patients; which (1) consists of taking of property of the providers, and endangering the lives and health of Medi-0Cal beneficiaries including the Plaintiff Mark Beckwith and those who are the patients and clients of the other Plaintiffs, all, in violation of and contrary to the Due Process Clause of the 14th Amendment and the Privileges and Immunities Clause of the U.S. Constitution.

32. Further, the fact that CMS has approved AB 97 and the 10% payment reduction of

AB 97 in respect to the Medi-Cal fee-for-service and managed care programs, is irrelevant, in that, CNS itself acted in excess of and without jurisdiction, contrary to Section 30A, the Supremacy Clause, and the 14th Amendment Due Process Clause, and Privileges and Immunities Clause, in approving the application of the State of California for a state plan amendment (SPA) to include this 10% payment reduction in the state plan required by 42 U.S.C. § 1396a(a) to be maintained at all times, as a condition to participate in the state/federal Medicaid program under the Medicaid Act; (all as set forth also, in the Second Claim for Relief).

33. The Plaintiffs have no plain, adequate, effective, or speedy relief whatsoever or at all, from the acts of the Director alleged above, which were void because in excess of and without jurisdiction, as set forth prior in this First Claim for Relief.

WHEREFORE, the Plaintiffs pray for relief as shall be hereinafter specified;

SECOND CLAIM FOR RELIEF

The Plaintiffs complain of the Secretary and for claim for relief allege:

34. Plaintiffs refer to and reallege each and all of the facts in the preceding Paragraphs as if fully set forth herein.

35. The Secretary acted in excess of and without jurisdiction, in whole and in every part, in approving the SPA for AB 97 and the 10% payment reduction of AB 97, for the same reasons as prior alleged in the preceding First Claim for Relief.

35. Independent of and without limitation of anything prior alleged, the Plaintiffs also allege that the Secretary violated Section 30A and the Administrative Procedure Act, by failing to consider whether the California legislature, and also the Director, considered the factors of efficiency, economy, quality of services, and equal access, and, failed to consider the fact that the State failed to consider any costs data or determine whether the reduced rates were reasonably related to costs of providers to furnish quality services; and the Secretary failed to consider whether the 10% reduced payment was consistent with quality of services and equal access; and,

used measures incompatible with and which could not possibly disclose whether the reduced payments were sufficient to enable providers, especially pharmacies, to provide quality services as required by Section 30A.

36. The Plaintiffs have no plain, adequate, effective, or speedy relief whatsoever or at all, from the acts of the Director alleged above, which were void because in excess of and without jurisdiction, as set forth prior in this First Claim for Relief.

WHEREFORE, the Plaintiffs pray for relief as follows:

1. That each of the defendants and their agents and successors be enjoined permanently, by preliminary injunction, and by temporary restraining order, from implementing AB 97 and from implementing the 10% payment reduction of AB 97, as amended by AB 102, whatsoever or at al.

2. That plaintiffs have reasonable attorneys fees, costs, and such other and further relief as may be just in the premises.

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CENTRAL DIST. OF CALIF.
LOS ANGELES
BY

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA, WESTERN DIVISION

MANAGED PHARMACY CARE, a California corporation; INDEPENDENT LIVING CENTER OF SOUTHERN CALIFORNIA, INC., a California corporation; CALIFORNIA FOUNDATION FOR INDEPENDENT LIVING CENTERS, a California corporation; GERALD SHAPIRO, Pharm.D., doing business as Uptown Pharmacy & Gift Shoppe; SHARON STEEN, doing business as Central Pharmacy; TRAN PHARMACY, INC., a California corporation, doing business as Tran Pharmacy; ODETTE LEONELLI, Pharm.D., doing business as Kovacs-Prey Pharmacy; MARKET PHARMACY, INC., doing business as Market Pharmacy; and MARK BECKWITH

Plaintiffs.

-vs.-

KATHLEEN SEBELIUS, Secretary of the U.S. Department of Health and Human Services; TOBY DOUGLAS, Director of Department of Health Care Services of State of California; and DOES 1 through 50

Defendants.

CV11-9211 R (PJWx).

NOTICE OF MOTION FOR PRELIMINARY INJUNCTION AND FOR TEMPORARY RESTRAINING ORDER

Date: Dec. 19, 2011
Time: 10 a.m.
Court: 8:
Judge: Manuel L.Real

ADDITIONAL COUNSEL FOR PLAINTIFFS:

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TO THE DEFENDANTS KATHLEEN SEBELIUS, SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES (HEREIN, "THE SECRETARY"), AND TO DEFENDANT TOBY DOUGLAS, DIRECTOR ('HEREIN, "DIRECTOR") OF THE DEPARTMENT OF HEALTH CARE SERVICES OF THE STATE OF CALIFORNIA, AND EACH OF YOU:

PLEASE TAKE NOTICE that on December 19, 2011, at 10 a.m. in Courtroom 8 of the above-entitled Court, second floor, 312 N.. Spring Street, Los Angeles, |California, that the plaintiffs will move the above-entitled Honorable Court for the following orders:

1. That the Secretary vacate and set aside, and do all things to cause to be vacated and set aside, that certain order, decision, and action of the Centers for Medicare and Medicaid Services (:"CMS"), and of the Secretary, which approved and accepted the State Plan Amendment ("SPA") submitted by the Department of Health Care Services ("DHCS") of the State of California, to reduce payments by 10% prospectively from October 27, 2011, and retroactively to June 1, 2011, to all non-institutional providers in the Medi-Cal fee-for-service program, including pharmacies, and to also refrain from making an actuarial equivalent reduction in payment, or any reduction in payment to, Medi-Cal managed care plans; until the final determination of the within action; and,

2. That the Director, and all employees, agents, and servants of the Director, and all persons working in concert with him, refrain from implementing Assembly Bill 97, and from implementing any 10% payment reduction, or any payment reduction, to providers in the Medi-Cal fee-for-service program, including pharmacies; and to Medi-|Cal managed care plans, pending the final determination of the within action;

PLEASE ALSO TAKE NOTICE that the Plaintiffs hereby apply to the Court in and by this Notice of Application for Temporary Restraining Order, for a temporary restraining order which restrains the Director, his agents, employees and contractors and all persons working in

concert with him, from implementing Assembly Bill 97 or the 10% rate cut of AB97, or any payment reduction whatsoever or at all, to Medi-Cal providers, including pharmacies, in the Medi-Cal fee-for service program, or to any Medi-Cal managed care plan, pending the hearing of the within Preliminary Injunction motion, served and filed herewith.

PLEASE ALSO TAKE NOTICE that. Each of the above motions for preliminary injunction and applications for temporary restraining orders, shall be made and based upon:

- the Complaint, and any amended complaint filed herein;
- the declarations on file and served herein;
- the within notice of motions and notice of application for TRO;
- all the papers on file in the within case;
- all the papers in Case No. 09-cv-03315 CAS (MANx) and in Case No. 09-cv-0382 CAS (MANx) in the above-entitled Court;
- the below memorandum of Plaintiffs
- all the documents that are served upon you herewith.

EACH OF YOU SHALL ALSO TAKE NOTICE THAT IN RESPECT TO THE APPLICATION OF PLAINTIFFS FOR A TEMPORARY RESTRAINING ODER, THAT YOU HAVE UNTIL 24 HOURS AFTER SERVICE UPON YOU OF THIS NOTICE OF APPLICATION FOR TEMPORARY RESTRAINING ORDER, TO SERVE AND FILE ANY WRITTEN RESPONSE THERETO WITH THE COURT.

WHEREUPON, the Plaintiffs pray for the relief specified in this notice of motion for preliminary injunction, and this notice of application for a temporary restraining Order.

Respectfully submitted,

Attorney for Plaintiffs

PLAINTIFFS' MEMORANDUM IN SUPPORT OF PRELIMINARY INJUNCTION, AND IN SUPPORT OF TEMPORARY RESTRAINING ORDER

INTRODUCTION

A quadriplegic Medicaid beneficiary, five pharmacies, two statewide pharmacy member groups, a large independent living center which assists thousands of disabled Medicaid recipients to find care and treatment from Medicaid providers, and the state association of independent living centers who likewise assist thousands of Medicaid recipients to find Medicaid care and treatment,

- (1) challenge the October 27, 2011 action of the defendant Secretary of U.S. Department of Health and Human Services, to approve a State plan amendment ("SPA") of the California Department of Health Care Services (DHCS) for a ten percent Medicaid provider payment cut ("10% rate cut"), not only prospectively, but retroactively to June 1, 2011; and (2) **request (i) a preliminary injunction, with (ii) an immediate temporary restraining order until the hearing of the preliminary injunction motion:** all, to preserve the status quo and prevent the destruction of the Medi-Cal program pending, successively, the hearing of the preliminary injunction motion, and the final determination of this case.

The preliminary basis or predicate for this challenge is that this 10% prospective-and-retroactive rate cut, – whether regarded as a mere 10% rate cut or as the 20% rate cut which in practicality it is, – was enacted in California Assembly Bill (AB) 97 (as amended by AB 102), for purely State budgetary reasons, hence clearly violated the basic procedural requirement of the Medicaid rate-setting statute, which, in the Ninth Circuit, *Orthopaedic Hospital v. Belshe*, 103 F.3d 1491, 1500 (9th Cir. 1997), requires the State's rate-setter to consider the factor of quality of services, and to set payment rates which bear a reasonable relationship to an efficient and economical

provider's costs to provide quality care.[1]

As pointed out by Chief Judge Levi, (now Dean of Duke Law School), in *Clayworth v. Bonta*, 295 F.Supp.2d 1110 (E.D.Cal. 2005, *rv'sd, other grounds*), at 1126:

> The [*Orthopaedic*] court held that Section 30(A) requires the State "to consider the costs of providing . . . services" and that reimbursement rates "should bear a reasonable relationship to an efficient and economical [provider's] costs of providing quality care." *Id.* at 1500. The court reviewed the State's rate setting under an arbitrary and capricious standard.
>
> The *Orthopaedic Hospital* rule is mostly procedural – the state agency must consider the proper factors in developing a reimbursement rate [in the Medicaid program]. Because costs were not considered by the State, the court did not reach the further question of whether the rate was appropriate under Section 30(A).
>
> The Ninth Circuit's approach has substantial practical benefits. . . . Furthermore, it is fair to assume that a rate that is set arbitrarily, without reference to the Section 30(A) requirements, is unlikely to meet the equal access and quality requirements. (Boldface emphasis supplied).

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[1] *Also see*, the prior cases of Plaintiffs' counsel (i.e., *Independent Living Center of Southern California, Inc. v. Shewry*, 543 F.3d 1050 (9t Cir. 2008); and *Maxwell-Jolly v. Independent Living*, 572 F.3d 644 (9th Cir. 2009), affirming preliminary injunctions in *Independent Living v. Shewry*, No. 2:08-cv-3315 CADS (MANx), (C.D.Cal. 2008) and in *Managed Pharmacy Care v. Maxwell-Jolly*, No. 2:09-cv-0382 CAS (MANx), (C.D.Cal, 2009), in which the State legislature was held to violate Section 30A when it reduced rates 10% in 2008, and 5% in 2009, for purely budgetary reasons; and, the same holding, in *Clayworth v. Bonta*, 295 F.Supp.2d 1110 (E.D.Cal. 2003, *rv'sd, other grounds*, 140 Fed.Appx. 677 (9th Cir. 2005), another case of Plaintiffs' counsel.

However, the Secretary has never accepted these views of the Ninth Circuit in *Orthopaedic* or in the *Independent Living* line of cases, that (1) the analysis of a State's setting of provider rates to see if the State has complied with Section 30A is primarily **procedural**, and (2) that the quality of services clause of Section 30A sets a minimum or floor beneath which a State may not set a Medicaid provider payment rate. To the contrary, the Secretary has always contended that efficiency, economy, and quality of care provision of Section 30A only sets an upper limit or ceiling above which a State may not set a Medicaid provider payment rate. *See*, the Solicitor General's brief in opposition to the holdings of *Orthopaedic*, filed when the Director (unsuccessfully) sought certiorari to the Supreme Court, following the Director's defeat in *Orthopaedic*. On Page 9, the SG's amicus brief stated the policy of the Secretary as follows:

> Section 30A requires each state to produce a *result*, not to employ any methodology for getting there, and absent proof that a rate structure results in inadequate access, States may say what they are willing to pay and see whether this brings forth an adequate supply of providers.

Given this background, it is not surprising that CMS, following the Secretary's views which are contrary to the Ninth Circuit's rulings, – which are the law in the Ninth Circuit, – violated Section 30A by approving the 10% rate cut of SB 97, both prospectively and retroactively to June 1, 2011, despite the fact that the enactment of AB 97's 10% rate cut was purely for budgetary reasons.

Therein CMS acted arbitrarily and capriciously, contrary to law, in approving the 10% rate cut, because it applied an incorrect standard for reviewing the action of the State to enact the 10% rate cut, both prospectively and retroactively to June 1, 2011.

I.e., the Ninth Circuit in the *Independent Living* line of decisions, (*Independent Living* v. *Maxwell-Jolly*, 572 F.3d at 654-656), noted the Secretary's above-stated contrary views as to interpretation of Section 30A, and rejected them: we owe the Secretary's views no deference, ruled the Ninth Circuit.

More specifically, the Ninth Circuit ruled:

> (T)he Director also argues that *Orthopaedic Hospital* is no longer good law because its interpretation of § 30(A) "conflicts with the interpretation of the federal agency that Congress vested with the authority to enforce and implement" the statute. By this, the Director apparently means that *Orthopaedic Hospital* conflicts with the interpretation of § 30(A) presented in an amicus brief filed by the Solicitor General when the Supreme Court asked him to opine on whether our decision in *Orthopaedic Hospital* was worthy of a grant of certiorari. In the process of recommending denial of certiorari, the Solicitor General opined that requiring States to reimburse medical providers at rates roughly equal to their costs ran counter to the text and legislative history of § 30(A). From this, the Director concludes that a "federal agency" repudiated our interpretation of § 30(A).
>
> Whatever the merits of the Solicitor General's views, we owe them no deference in this case. Although at one time the Supreme Court suggested that a legal opinion expressed by an agency in the course of litigation may be entitled to deference, [citation], it subsequently limited such deference to an agency's interpretations of ambiguities in its own regulations. [Citation]. (572 F.3d at 654). (Boldface emphasis supplied).

The Ninth Circuit then went on in the same *Independent Living* decision to reiterate the Ninth Circuit rule that enacting a Section 30A provider rate cut for purely budgetary reasons, violates Section 30A, and cannot be disregarded in reviewing a State's action to reduce Medicaid provider payments. Thus *Independent Living* held, 572 F.3d at 655-656:

> First, even those courts that have rejected *Orthopaedic Hospital's* procedural requirements have generally recognized that state Medicaid rates may not be based solely on state budgetary concerns. See *Rite Aid*, 171 F.3d at 856: "(B)udgetary considerations may not be the sole basis for a rate revision . . . "), *see also Beno v. Shalala*, 30 F.3d 1057, 1069 n.30 (9th Cir. 1994) [citations].
>
> In this case, the record supports the district court's conclusion that "the only reason for imposing the cuts was California's current fiscal emergency." The legislation was passed in an emergency session called to "address[] the fiscal emergency declared by the Governor. Thus, quite apart from any procedural requirements established by *Orthopaedic Hospital*, the State's decision to reduce Medi-Cal reimbursement rates based solely on state budgetary concerns violated federal law.

2. Further, because the expressed policy of the Secretary, contrary to the Ninth Circuit, is that costs of providers are not relevant or required to be considered by a State rate-setter, in reducing provider payments, it is manifest that the Secretary failed to review whether the reduced 10% rate would cover costs of providers to furnish quality care, as well as failed to review whether the State considered the costs of providers, (either with or without responsible costs data), in approving the 10%

rate cut on October 27, 2011.

Hence the October 27, 2011 action of the Secretary to approve the 10% rate cut, was clearly erroneous, because the Secretary, – due to her erroneous view that costs of providers are irrelevant, and, that it is irrelevant whether the reduced payments would cover providers' costs, – entirely failed to consider the relevant issue of whether the reduced payment rates under the 10% rate cut would cover providers' costs. Hence the Secretary acted arbitrarily and capriciously, contrary to law, and contrary to the requirements of 5 U.S. Code, sec. 706, in approving the 10% rate cut SPA for providers, including pharmacies, in the Medi-Cal fee-for-service program.

3, **Worse, in respect to pharmacies, the whole issue of whether a 10% payment cut would prevent them from dispensing brands at all, and from dispensing the many high priced generics, by reducing their Medi-Cal reimbursement to below their costs to acquire-and-dispense these drugs, was addressed in suits by Medicaid beneficiaries and pharmacies, (many of them the same as in the within suit), in *Independent Living v. Shewry*, No. 2:08-cv-03315 CJAS (MANx) – a 10% payment cut under AB 5, – and in *Independent Living v. Maxwell-Jolly*, No. 2:09-cv-0382 CAS (MANx), – a 5% payment cut under AB 1183. In these cases the court found on substantial evidence that both a 10% payment cut and even a 5% payment cut would result in pharmacies not being paid their costs to acquire-and-dispense most brands, and many generics; And that many community pharmacies would cease dispensing these prescribed drugs to Medi-Cal patients, or quite the Medi-Cal program entirely.**

Yet the Secretary entirely failed, and in essence refused to consider either these findings of fact, or the evidence upon which they were based, solely because in the erroneous view of the Secretary, such evidence of providers' costs, and that pharmacies would not be reimbursed their costs, under a 10% rate cut, was not relevant.

Therein the action of the Secretary to approve the SPA to allow the State to reduce payments to pharmacies by 10%, prospectively, and also to reduce payments by another 10%, retroactively to June 1, 2011, was clearly arbitrary and capricious, and contrary to law, due to the erroneous view of the Secretary that providers' costs are irrelevant in determining whether a State's payment reduction complies with Section 30A,

Note: The opinion of Richard D. Wilson, C.P.A., in the 10% rate reduction case above cited

by the Plaintiffs, is included in the Schedule of Declarations served and filed herewith. C.P.A. Wilson's findings and conclusions were that under a 10% payment cut, pharmacies in the Medi-Cal program, would have to stop dispensing most brands, and, also, many generics, or, quit the Medi-|Cal program entirely. The Wilson declaration, – **as well as the array of declarations filed herewith of the Plaintiffs, (which are contained in the Schedule of Declarations filed herewith)**, – show that unless a TRO and then injunctive relief are promptly issued, that millions of Medi-Cal recipients will become deprived of any access to their brand drugs, and to many generics. This in turn, will cause widespread suffering, return to institutions in order to obtain their medications, for thousands of Medi-Cal recipients, and death for some.

SUMMARY, AND PRAYER FOR PRELIMINARY INJUNCTION AND TRO:

From the foregoing, and for the above reasons, it is clear that the Secretary, acting by and through CMS did, on October 27, 2011, act arbitrarily and capriciously, and in gross abuse of discretion, and not in accordance with law, (namely, contrary to Section 30A), and in excess of and without statutory jurisdiction, to approve the DHCS application for approval of its SPA to permit DHCS and the Director to reduce payment rates to all Medicaid provider in California, including pharmacy providers, by 10%, both prospectively, and retroactive to June 1, 2011.

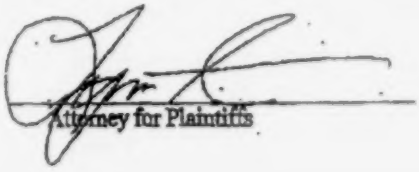
All this, despite the undisputed fact that the State legislature enacted the 10% rate cut of AB 97, and the Director adopted a policy and decision to implement the 10% rate cut at once, for purely budgetary reasons; and without any consideration of the factor of quality of care as required by Section 30A, or whether providers, including pharmacies, could sustain the 10% rate cut, both prospectively and retroactive to June 1, 2011, without loss of quality of care (contrary to and in violation of Section 30A): all of which was I violation of the Administrative Procedure Act, 5 U.S.C. § 702 et seq., and especially in violation of 5 U.S.C. § 706, subds. (1) and (2)(A), (C), (E) and (F), and in violation of all federal laws and regulations made and provided therefore.

Accordingly, the Plaintiffs pray that (1) a permanent and a preliminary injunction issue,

commanding the Secretary to cause the CMS decision and action of October 27, 2011 to approve the State's SPA for the 10% rate cut to be vacated and set aside in whole and in every part, and that the Director be ordered to refrain form implementing AB 97 or any 10% rate cut or any lesser rate cut, whatsoever or at all, pending the final determination of the within complaint of the Plaintiffs; and (3) that a temporary restraining order issue, ordering the Director and his agents not to implement AB 97 or its 10% rate cut whatsoever or at all, until the court determines the above-mentioned motion of the Plaintiffs for a preliminary injunction; and, for such other and further relief as may be proper.

Dated: November 7, 2011.

Respectfully submitted,



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OCT - 3 2011

Supreme Court, U.S.
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November 18, 2011

By Hand Delivery

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SUPREME COURT, U.S.

Honorable William K. Suter
Clerk
Supreme Court of the United States
One First Street, N.E.
Washington, D.C. 20543

Re: *Toby Douglas, et al.* v. *Independent Living Center of Southern California, Inc., et al.*, Nos. 09-958, 09-1158, 10-283

Dear General Suter:

This letter brief is submitted on behalf of certain respondents[1] in response to the Court's order of November 4, 2011, which directed the parties and the Solicitor General to file supplemental letter briefs addressing "[w]hat should be the effect, if any, of the developments discussed in the letter submitted by the Solicitor General on October 28, 2011, on the proper disposition of this case."

The developments discussed in the Solicitor General's letter concern recent decisions by the Centers for Medicare & Medicaid Services (CMS), the agency within the U.S. Department of Health and Human Services that has primary responsibility for administering the federal Medicaid program. In those decisions, issued less than a month after oral argument in the above-referenced case, CMS relied on information newly submitted by California to the agency in September 2011 and approved several, but not all, of the Medicaid reimbursement rate reductions at issue in this case for certain limited time periods beginning on January 1, 2011. S.G. Ltr. 1-3. Before California presented this new material to the agency, CMS had previously found those reductions to violate Section 30(A) of

[1] The respondents joining in this submission are those that joined the merits briefs filed by (i) the intervenor respondents in No. 09-958 and *California Pharmacists* respondents in No. 09-1158, (ii) the *Dominguez* respondents in No. 09-1158, and (iii) the *Santa Rosa* respondents in No. 10-283.

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the Medicaid Act. *Id.* The lower courts in this case had likewise previously held, before CMS issued its initial disapprovals, that California's reductions were inconsistent with Section 30(A), and therefore preempted, and entered preliminary injunctions enjoining the California Department of Health Care Services (DHCS) from implementing them.

For the reasons elaborated below, the recent CMS decisions do not moot the dispute between the parties. There remains a live controversy. Nonetheless, the legal landscape that prompted the Court to grant certiorari has now changed dramatically and therefore the Court may wish to consider whether the proper course to follow at this time is to dismiss the writs of certiorari as improvidently granted. Due to California's concessions before CMS, only a few months of reimbursement claims remain at issue in this case; moreover, due to intervening state legislation primarily adopted after issuance of the writs, the preliminary injunctions at issue have no current prohibitive effect. Because the case has come to this Court on review of the grant of a preliminary injunction, dismissal of the writs will simply cause these matters to proceed in the district courts, which will be able to take into account CMS's intervening decisions in finally disposing of the claims.

1. We begin by reviewing the background of these cases and the circumstances that have changed since the Court granted certiorari. In 2008 and 2009, a diverse group of Medicaid health care and service providers and beneficiaries brought five lawsuits to enjoin rate reductions prescribed by three California statutes: Assembly Bill 5 (AB 5), Assembly Bill 1183 (AB 1183), and Senate Bill 6 (SB 6). The lower courts uniformly held that California had implemented the reductions for budget reasons alone, without conducting the reasonable access studies required by Section 30(A), and further found that the State had improperly implemented the reductions without first obtaining CMS approval. *E.g.*, Pet. App. 28-29, 58-93 (No. 09-958). The courts therefore held the statutes to be preempted, and entered preliminary injunctions halting DHCS from implementing the rate reductions because respondents were likely to succeed on the merits and the reductions would cause irreparable harm, particularly to beneficiaries of Medicaid who would be denied access to critical medical care. *Id.*

In September 2008, after the first of these lawsuits had been filed, California belatedly submitted certain of the rate reductions at issue—those imposed by AB 5 and AB 1183—to CMS for review in separate agency proceedings. U.S. Pet. Br.

App. 1a-3a (No. 09-958). (California did not submit to CMS for review the reductions set forth in SB 6.) In November 2010, after California had consistently failed to respond to requests from CMS (originally presented in December 2008) for information regarding the rate reductions submitted for its review, CMS disapproved those reductions. *Id.* It explained that it could not approve the reductions because, among other things, "California has not demonstrated that it would meet the conditions set out in [Section 30(A)]." *Id.* at 2a (letter dated Nov. 18, 2010). DHCS requested reconsideration of the disapprovals, *id.* at 5a-7a, thereby triggering a formal administrative hearing. Those reconsideration proceedings were pending when this Court granted the petitions for certiorari on January 18, 2011.

CMS now has determined, based on materials submitted in September 2011 during a separate federal agency review process, that some of the rate reductions are, at least in part, consistent with the Medicaid Act. On October 27, 2011, after reviewing the newly submitted materials, CMS issued new decisions approving several of the rate reductions prescribed by AB 5 and AB 1183 for certain periods after January 1, 2011. S.G. Ltr. 1-3. In particular, as explained in the Solicitor General's letter, it now has approved the one- and five-percent reductions in prescription drug and health services reimbursement rates set forth in AB 5 and AB 1183, and the rate reductions and caps on non-contracting hospitals prescribed by those bills. *Id.* at 3. However, in light of certain concessions by California, CMS withheld approval of the rate reductions for the period before January 1, 2011, when the preliminary injunctions in this case were in effect, and the agency did not approve the across-the-board ten-percent reductions imposed by AB 5, in light of California's withdrawal of its request for approval of those reductions (which, as discussed below, had expired in February 2009). *Id.* As previously stated, CMS did not approve or address the In-Home Supportive Services (IHSS) reductions prescribed by SB 6, because California never submitted those reductions for agency review. *Id.* at 1 n.*.[2]

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[2] If the Court does not dismiss the writs, the lack of any federal agency proceedings concerning the IHSS reductions demonstrates why injunctions under the Supremacy Clause are, in general, necessary and important. *See* Cal. Pharm. Merits Br. 19-31; Dominguez Merits Br. 7-20; ILC Merits Br. 19-35; Santa Rosa Merits Br. 12-22. The reductions set forth in SB 6 were targeted at home care providers, who provide critical support services such as bowel and bladder care, ambulation, bathing, oral hygiene, and feeding for individuals who could not otherwise care for themselves. These services and others enable low-income elderly, blind, or disabled individuals to remain in the

There have been a number of other relevant developments following issuance of the writs. Most significant for these purposes, all of the rate reductions subject to the preliminary injunctions in this case have been either repealed, superseded, or suspended. The ten-percent rate reductions prescribed by AB 5 expired in February 2009. See 2008 Cal. Stat. c. 758, §§ 44-45. Certain of the reductions prescribed by AB 1183 were repealed as of April 2011, see 2011 Cal. Stat. c. 3, §§ 93.2, 93.5; 2011 Cal. Stat. c. 19, § 4; 2011 Cal. Stat. c. 29, §§ 12, 13, and others imposed by that bill—in addition to the remaining reductions set forth in AB 5—were superseded by new rate cuts deemed effective as of June 1, 2011, see 2011 Cal. Stat. c. 29, § 13; 2011 Cal. Stat. c. 3, § 93.2.[3] By separate legislation, the California Legislature delayed implementation of the IHSS rate reductions contained in SB 6 until the *later* of July 2012, or a final judicial decision not subject to appeal upholding their validity. See 2010 Cal. Stat. c. 725, § 25, *codified at* Cal. Welf. & Inst. Code. § 12306.1(d)(7)(B). The result of these developments is that, as of June 2011 and continuing to this time, none of the rate reductions challenged in this case is currently in effect.

2. Although the rate reductions at issue in this case are not currently effective, and although CMS has now approved several of those reductions as consistent with federal law, respondents do not believe this case to be formally moot.

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community rather than being placed in institutions. Cal. Welf. & Inst. Code § 12300(a)-(c). Absent the injunction entered in *Dominguez v. Schwarzenegger*, No. 09-02306 (N.D. Cal.), California would have reduced provider payments to just above the minimum wage, causing many providers to quit their jobs and forcing many recipients into nursing homes or other institutions. *See, e.g.*, Dominguez Cert. Opp. Br. 6-7 (No. 09-1158). Because California never sought CMS approval of these reductions, plaintiffs in the *Dominguez* case have no other avenue, such as a claim under the Administrative Procedure Act, to challenge those reductions that are preempted under the Medicaid Act—their only option is an injunction action under the Supremacy Clause.

[3] The most recent California legislation, prescribing the superseding rate reductions, expresaly conditions implementation of those reductions on prior CMS approval. *See, e.g.*, 2011 Cal. Stat. c. 29, § 13. This condition is fully appropriate—and indeed required—because, as both CMS and federal courts have consistently ruled, States are not permitted under the Medicaid Act to implement rate reductions unless and until those reductions have been reviewed and approved by CMS. *See, e.g., Exeter Mem'l Hosp.* v. *Belshe*, 145 F.3d 1106, 1108 (9th Cir. 1998). Although California has not conditioned implementation of the IHSS reductions set forth in SB 6 (at issue in the *Dominguez* matter) on CMS approval, as discussed in the text of this letter, implementation of those reductions has been expressly conditioned on court approval.

Mootness arises when the judgment below no longer has any prospective effect on the legal rights and obligations of the parties. See, *e.g.*, *Powell* v. *McCormack*, 395 U.S. 486, 496 (1969). Here, however, even if the preliminary injunctions have no immediate prohibitive effect, they continue to affect the rights and obligations of the parties because their *retrospective* validity has ongoing relevance to California's related claims for reimbursement. If the injunctions in this case are held to be invalid as of the time they were issued, then California may—and has said that it will, see DHCS Merits Br. 9 n.3—seek reimbursement of the additional funds it paid to the plaintiffs in this case as a result of those injunctions. See S.G. Ltr. 3 (noting possibility of "recoupment" by California of funds allegedly overpaid under injunctions). A situation in which the enjoined statute has been repealed but the injunction has ongoing legal or practical consequences for a party continues to present a "live" controversy. See, *e.g.*, *Firefighters Local Union No. 1784* v. *Stotts*, 467 U.S. 561, 568-72 (1984); see also *Indep. Living Ctr. of S. Cal.* v. *Maxwell-Jolly*, 590 F.3d 725, 729-30 (9th Cir. 2009) (holding prior decision not moot based on Petitioner's representations to Supreme Court of intent to seek recoupment of monies paid pursuant to lower court injunction). Accordingly, the dispute between the parties is not moot and thus the judgments below are not subject to vacatur under this Court's decision in *United States* v. *Munsingwear, Inc.*, 340 U.S. 36 (1950).[4]

3. Although the case may not be properly dismissed for formal mootness, these recent developments are an appropriate basis upon which this Court may wish to dismiss the writs as improvidently granted. This Court has recognized that dismissal of the writ is appropriate when there is a material change in circumstances relevant to the judgments below, *e.g.*, *Taggart* v. *Weinacker's, Inc.*, 397 U.S. 223, 224-25 (1970) (per curiam), or the litigation is no longer "meaningful," in the sense that this Court's judgment will have no significant impact on the parties, *e.g.*, *The Monrosa* v. *Carbon Black Export, Inc.*, 359 U.S. 180, 184 (1959). Both factors are applicable here.

a. The CMS approvals represent a material change in circumstances because they are relevant to the judgments below. Those judgments were based on the

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[4] This case may be rendered moot if California disclaimed any right to reimbursement. In that event, the judgments of the lower courts would still not be subject to vacatur. *U.S. Bancorp Mortg. Co.* v. *Bonner Mall P'ship*, 513 U.S. 18, 24 (1994) (noting that vacatur is not warranted under *Munsingwear* when case is rendered moot by voluntary action of petitioner).

district courts' determinations—affirmed by the Ninth Circuit—that the rate reductions were enacted without the reasonable access studies required by Section 30(A) of the Medicaid Act. *E.g.*, Pet. App. 28-29, 58-93 (No. 09-958). CMS now has determined, based on materials submitted in September 2011 during a separate agency review process, that the new information DHCS has submitted regarding the effects of the rate reductions was sufficient to conclude that some of the rate reductions are (at least in part) consistent with the Medicaid Act. S.G. Ltr. 1-3. The lower courts should be allowed to consider these new findings, and the materials submitted to the agency in support thereof, in assessing the proper final disposition of these cases.

To be sure, the CMS findings do not directly resolve whether the Constitution supports a right of action to enjoin preempted state laws. However, review of that fundamental constitutional question was granted by this Court on the assumption that the state laws at issue are preempted and the injunctions are of continuing effect. See Cal. Pharm. Merits Br. 1; Dominguez Merits Br. 28; ILC Merits Br. 57-59; Santa Rosa Merits Br. 8-9. Insofar as those judgments may be affected by the recent CMS findings, potentially rendering it unnecessary to reach the constitutional question presented here, that question should not be addressed until the lower courts have resolved any issues raised by the CMS findings. See, *e.g.*, *Ashwander* v. *TVA*, 297 U.S. 288, 346-49 (1936) (Brandeis, J., concurring) ("The Court will not 'anticipate a question of constitutional law in advance of the necessity of deciding it.'").[5]

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[5] The CMS review process is not, as explained in respondents' merits briefs, a prerequisite to a preemption right of action in the federal courts and cannot reasonably be interpreted as such, particularly given that private parties cannot initiate CMS review and therefore could not be expected to "exhaust" it. *See* Cal. Pharm. Merits Br. 46-52; Dominguez Merits Br. 25-27; ILC Merits Br. 63-66; Santa Rosa Merits Br. 44; *see also, e.g.*, *Patsy* v. *Bd. of Regents*, 457 U.S. 496, 501 (1982); *Rosado* v. *Wyman*, 397 U.S. 397, 405-06 & n.8 (1970). For example, California chose to avoid the CMS review process entirely with respect to the reductions set forth in SB 6, leaving plaintiffs challenging those reductions (in *Dominguez v. Schwarzenegger*, No. 09-02306 (N.D. Cal.)) with no alternative but to seek injunctive relief under the Supremacy Clause. Moreover, as Justice Kennedy has correctly explained, "plaintiffs may vindicate ... pre-emption claims by seeking declaratory and equitable relief in the federal district courts through their powers under federal jurisdictional statutes," even where other remedies—in that case, damages under 42 U.S.C. § 1983—are statutorily unavailable to the plaintiffs. *Golden State Transit Corp.* v. *City of L.A.*, 493 U.S. 103, 119 (1989) (Kennedy, J., dissenting on other grounds).

There is no reason, and no basis, for this Court to address these matters in the first instance. This is particularly true because the impact of the recent CMS decisions on the preliminary injunctions in this case, which were entered by the lower courts both before and during the period in which CMS review was pending, presents a number of new intertwined and complex administrative law issues. These include:

(1) the effect of CMS's decisions on the injunctions;

(2) the effect of CMS's decisions on the question of preemption, including whether this new administrative action should be reviewed under the Administrative Procedure Act in the first instance;

(3) the standard of review and degree of deference that should be applied in evaluating the federal and state agency actions;

(4) in examining California's compliance with the substantive Medicaid standards, what record materials are properly before the courts.

Certain of these issues were mentioned during oral argument in this Court, but they have not been briefed by the parties at any stage or considered in the first instance by the courts below.[6]

In short, although these recent developments in this case may affect the outcome—and thereby render the specific question that this Court granted certiorari to decide of mere "scholarly interest," *Rice* v. *Sioux City Mem'l Park Cemetery, Inc.*, 349 U.S. 70, 74 (1955)—the issue of what impact CMS's approvals has on the underlying preemption question is not properly before the Court.

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[6] The Solicitor General's letter refers also to recent CMS approvals of certain new Medi-Cal provider payment reductions effective for dates of service on or after June 1, 2011, based on California Assembly Bill 97 (2011). S.G. Ltr. 3. These new reductions are not covered by the preliminary injunctions at issue before this court. Some of the respondents in this case have brought separate actions challenging those CMS approvals of the new payment reductions as both "arbitrary" and "capricious" pursuant to the Administrative Procedure Act, 5 U.S.C. § 706(2)(A), and preempted under the Supremacy Clause. *E.g.*, *Managed Pharmacy Care* v. *Sebelius*, No. 11-9211 (C.D. Cal. filed Nov. 4, 2011). That these new actions squarely present the question of the effect of the CMS approvals decisions on the issue of preemption highlights why this Court should not decide this case in its current posture, where those issues were neither briefed nor addressed at any point.

Accordingly, those approvals provide a basis on which this Court may wish to dismiss the writs as improvidently granted.

b. This is no less true because the CMS approvals do not address all of the rate reductions. See S.G. Ltr. 1 n.* (noting that California withdrew its request for approval of certain reductions in AB 5 and did not seek approval of reductions in SB 6). The intervening state legislation discussed above independently warrants dismissal of the writs. That legislation repealed or superseded the reductions in AB 5 and AB 1183, and suspended implementation of the IHSS reductions in SB 6 until the later of July 1, 2012, or the date on which "a court of competent jurisdiction has issued an order, that is not subject to appeal or for which the time to appeal has expired, upholding [their] validity." Cal. Welf. & Inst. Code § 12306.1(d)(7)(B). Because the plaintiffs challenging the SB 6 reductions (in *Dominguez* v. *Schwarzenegger*, No. 09-02306 (N.D. Cal.)) have also asserted objections to the reductions that are independent of Section 30(A), those IHSS reductions will therefore now not take effect until after a final, non-appealable disposition resolving all challenges to their validity, and for that reason the preliminary injunction that issued in that matter (in 2009, before enactment of the intervening state suspension statute) is no longer effective or necessary. As several respondents argued at the certiorari stage, the intervening legislation therefore makes review on certiorari unwarranted. *See* Joint Supp. Cert. Br. 3 (No. 09-1158).

c. For closely related reasons, dismissal of the writs may be appropriate because, in light of these intervening circumstances, this Court's judgment may have limited practical impact. Although the preliminary injunctions issued by the district courts were of critical importance in preventing California from unlawfully implementing rate reductions that CMS had not yet reviewed, and those that CMS never approved (including the IHSS reductions in SB 6 and reductions in other provider rates during periods before January 1, 2011), and further in avoiding the irreparable harm that would have otherwise resulted to these respondents, they have no current effect, so the judgment of this Court would have no immediate or direct effect on DHCS or the plaintiffs. The only relevance of the judgment would be to determine whether or not California could seek reimbursement for amounts previously paid as a result of the preliminary injunctions.

Respondents believe that the amounts at issue in such a claim would be relatively small. Although California has in the past (including in filings before this Court) suggested that it would seek reimbursement of all amounts allegedly

overpaid as a result of the injunctions, see DHCS Merits Br. 9 n.3, in the reconsideration proceedings before CMS, the State apparently conceded that it would not seek reimbursement for periods before 2011 (and affirmatively withdrew its request for approval of the ten-percent reductions imposed by AB 5). S.G. Ltr. 2-3. CMS relied on these concessions in approving the rate reductions under review. *Id.* In light of these concessions, and the legislation repealing or superseding the enjoined rate reductions as of (at the latest) June 2011, the only period for which the State might still seek recoupment for some of the reductions are certain three-month periods during the first few months of this year. This potential relief renders the case much less "meaningful" for the parties. *Monrosa*, 359 U.S. at 184. In these circumstances, where a case presents a substantial constitutional question but only "small embers of controversy ... remain," it is appropriate to dismiss the writs as improvidently granted. *Taggart*, 397 U.S. at 225.

* * *

Review of interlocutory decisions is generally disfavored because "many orders made in the progress of a suit become quite unimportant by reason of the final result, or of intervening matters." *Am. Constr. Co.* v. *Jacksonville, T. & Key W. Ry.*, 148 U.S. 372, 384 (1893); see also *United States* v. *Nixon*, 418 U.S. 683, 690-91 (1974). That is what has occurred here. Legislative and administrative agency developments have shifted the focus of what remains for consideration and disposition in these matters. Under these changed circumstances, the Court should consider whether the writs should be dismissed as improvidently granted so that these remaining issues are posed "less abstractly," *Monrosa*, 359 U.S. at 184, and with the benefit of relevant further briefing and legal and factual development by the lower courts.

Sincerely,

Carter G. Phillips

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CERTIFICATE OF SERVICE

Nos. 09-958, 09-1158, 10-283

TOBY DOUGLAS, *et al.*,
Petitioners,

v.

INDEPENDENT LIVING CENTER OF SOUTHERN CALIFORNIA, INC., *et al.*,
Respondents.

I, Carter G. Phillips, do hereby certify that, on this 18th day of November, 2011, I caused a copy of the supplemental brief on behalf of respondents, in response to the Court's order of November 4, 2011, to be served by first class mail, postage prepaid on the following:

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November 18, 2011

By Hand Delivery

Honorable William K. Suter
Clerk
Supreme Court of the United States
One First Street, N.E.
Washington, D.C. 20543

Re: *Toby Douglas, et al. v. Independent Living Center of Southern California, Inc., et al.*, Nos. 09-958, 09-1158, 10-283

Dear General Suter:

This letter brief is on behalf of the plaintiffs-respondents Independent Living Center of Southern California, Inc., et al., ("ILC Plaintiffs") in Nos. 09-958 and 09-1158 in response to the November 4, 2011 order of the Court to file supplemental letter briefs on:

> "What should be the effect, if any, of the developments discussed in the letter submitted by the Solicitor General on October 28, 2011, on the proper disposition of this case."[1]

10% rate cut of AB 5

In No. 09-958 the ILC Plaintiffs obtained preliminary injunctions which enjoined the 10% Medicaid provider rate cut of California Assembly Bill (AB) 5:

> - (1) for services on or after July 1, 2008 of physicians, dentists, optometrists, clinics, adult day care health centers, and, for prescription drugs, (August 18, 2008 order);

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[1] The ILC Plaintiffs filing this letter brief are:

In No. 09-958: Independent Living Center of Southern California, Inc.; Margaret Dowling; Mark Beckwith; Gerald Shapiro, Pharm.D., dba Uptown Pharmacy & Gift Shoppe; Sharon Steen, dba Central Pharmacy; Tran Pharmacy, Inc.; Gray Panthers of San Francisco; and Gray Panthers of Sacramento.

In No. 09-1158: Independent Living Center of Southern California, Inc.; Margaret Dowling; Mark Beckwith; Gerald Shapiro, Pharm.D., dba Uptown Pharmacy & Gift Shoppe; Sharon Steen, dba Central Pharmacy; and Tran Pharmacy, Inc.

- (2) for services on or after November 17, 2008 of home health agencies and non-emergency medical transporters (NEMT), (November 17, 2008 order).

The 10% rate cut of AB 5 was terminated by the State legislature as of February 28, 2009.[2]

5% rate cut of AB 1183

In No. 09-1158 the ILC Plaintiffs also obtained preliminary injunction which enjoined the successor 5% Medicaid provider rate cut of AB 1183, which had been enacted to go into effect March 1, 2009 in respect to prescribed drugs.

The 5% rate of AB 1183 in respect to prescribed drugs was terminated by the State legislature as of May 31, 2011.[3]

Administrative action

On November 17, 2010, the Centers for Medicare and Medicaid Services (CMS), an agency within the U.S. Department of Health and Human Services (HHS), disapproved the State Plan Amendments (SPAs) submitted by the State of California for the rate cuts of AB 5 and AB 1183.[4]

CMS disapproval was on the basis that "California has not demonstrated that it would meet the conditions set out in" the Medicaid payment-setting statute, Social Security Act § 1902(a)(30)(A) – "Section 30A."

Since then the following has occurred:

On October 27, 2011, the State withdrew its Request for Reconsideration of CMS' November, 2010 disapproval of the SPA for the 10% rate cut of AB 5, for the eight services which are the subject of the two injunctions obtained by the ILC Plaintiffs in 2008, in No. 09-958.

On October 27, 2011, the State also withdrew its Request for Reconsideration of the CMS disapproval of the SPA for the 5% rate cut of AB 1183 for pharmacy services (including prescribed drugs).

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[2] § 14105.19 Cal. Welf. & Inst. Code, amended Sept. 30, 2008 by Sec. 44, AB 1183.

[3] § 14105.191 Cal. Welf. & Inst. Code, amended March 24, 2011 by Sec. 93.2, AB 97.

[4] This action of CMS was two years after the 10% rate cut of AB 5 was enacted to commence, and 20 months after the 5% rate cut of AB 1183 was enacted to commence.

In the meanwhile:

> In December 2010, the State filed SPA 10-024 which requested CMS to approve the 5% rate cut of AB 1183 for the limited three month period, March - May, 2011; and the State **for the first time submitted information or data to CMS to support its claim that the 5% rate cut of AB 1183 for this window period, complied with the Medicaid rate-setting statute.**
>
> The State legislature enacted AB 97, which, – relative to the subject of this letter brief, – terminated the 5% rate cut of AB 1183 as of May 31, 2011.

Then, on October 27, 2011, CMS – **based on the new information or data submitted by the State for the very first time,** – approved the State's new SPA 10-024 for the 5% rate cut of AB 1183 for pharmacy services for the 3-month period March through May, 2011.

****

In summary, the State in effect:

> - has now withdrawn its claim to CMS for CMS approval of the 10% rate cut of AB 5 – which rate cut is the sole subject of No. 09-958, and,
>
> – has now withdrawn as well its claim to CMS for CMS approval of the 5% rate cut of AB 1183, which rate cut is a primary subject of No. 09-1158, – (with one exception, that CMS has now approved the 5% rate cut of AB 1183 for the limited period of three months for only one service, (pharmacy services), due to the fact that the State, for the first time, submitted information or data to CMS which afforded CMS, for the first time, a factual basis or floor upon which to consider and rule that the 5% rate cut of AB 1183 complied with the Medicaid rate-setting statute).

Therefore, in purview of the kaleidoscope of prospective and retroactive actions of CMS and the State, listed above, the ILC Plaintiffs respectfully suggest to the Court that the within three preliminary injunctions obtained by the ILC Plaintiffs in Nos. 09-958 and 09-1158, have become even more unsuitable for certiorari review than they were when respondents first suggested that review by the Court is premature.

Thus the ILC Plaintiffs respectfully suggest that certiorari was improvidently granted, in both of the 09-958 and 09-1158 cases, and that appropriate orders be issued to dismiss these petitions of the petitioner Director, upon that ground.

Discussion

As the Court knows from the record in these cases, the preliminary injunctions in 09-958 and 09-1158 were issued because the Director failed to show the district court any evidence tending to

show that the State complied in any respect with the Medicaid rate-setting statute.

As the October 28, 2011 letter of the Solicitor General shows, the CMS disapproved the State's applications for SPA approvals to implement the same 10% and 5% rate cuts of AB 5 and AB 1183, on the exact same ground as did the district court: namely, that the State failed to provide any information showing that the State complied with the Medicaid rate-setting statute in any respect.

Hence there was simply no discrepancy between the actions of the district court, and the actions of CMS, or the rationales of either for such actions, for disapproving the 10% and the 5% rate cuts of AB 5 and AB 1183. Hence the intimations by the Director in his petitions for certiorari, that there was some inappropriate conflict between the lower court judicial decisions, and their rationale, and the decisions that CMS would render, and CMS' rationale, in respect to the State's non-compliance with the Medicaid rate-setting statute, have proven to be baseless such that, the ILC Plaintiffs respectfully suggest, the grant of certiorari in 09-958 and 09-1158 should now be recognized as having been improvidently granted.

The ILC Plaintiffs also point out to the Court that now, when and if the Director returns to the district court to seek an order to terminate the existing preliminary injunction enjoining the 5% rate cut of AB 1183, – for the limited three-month window which has now recently been approved by CMS, – that if the Director submits the same information or data to the district court, which the Director presented to CMS to obtain CMS approval for the 5% rate cut of AB 1183 for this three-month period, – that the district court might agree with the Director, and, issue an order to terminate this particular preliminary injunction for this limited three-month period. **Such a result would thereby render completely unnecessary any application to the Court by the Director,** for any relief whatsoever in the matter of the 5% rate cut of AB 1183, and would relieve the Court of any necessity to construe the Constitution in respect to this remaining matter, at all.

Summary and prayer

Based on the above facts, the ILC Plaintiffs respectfully suggest to the Court that the within certiorari proceedings in Nos. 09-958 and 09-1158 should now be dismissed, for having been improvidently granted or, on the basis that ensuing events, above related, have rendered improvident the initial grant of certiorari in these cases, Nos. 09-958 and 09-1158.

This, in line with the wise policy of the Court, which has served it through many storms, to avoid engaging in construing the Constitution, where there is no necessity to do so.

Respectfully submitted,

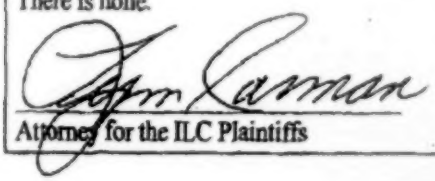
Lynn S. Carman
Stanley L. Friedman

By _____
Attorneys for the ILC Plaintiffs

(Rule 29 Statement below):

RULE 29 STATEMENT

There is none.



Attorney for the ILC Plaintiffs